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ABSTRACT

The Family to Family Initiative of the Annie E. Casey Foundation has encouraged states to reconceptualize, redesign, and reconstruct their foster care systems. By 1996, the Foundation had selected and funded five states and six counties in two other states to develop family-centered, neighborhood-based family foster care systems within one or more local areas. This report describes organization development and systems thinking as tools to change foster care systems. Organization development refers to a set of methods and tools for understanding, introducing, managing, and sustaining change over time to increase organizational effectiveness. Organization development can help a new system while still retaining the best features of the old one. Systems thinking is useful in understanding and addressing organizational problems in ways that connect each person's part to the whole picture. Thinking systematically can help with problem identification and indicate where it would make the most sense to focus time and attention in order to address those problems. The discussions of organization development and systems thinking are followed by four case studies that use systems thinking to identify and understand organizational problems and introduce tools that can help address them. The case studies are built on experiences the Foundation had working with child welfare agencies and state departments of human services as they introduced the principles of Family to Family. For each case, tools appropriate to that case are identified, with a formal description of each of the tools used. (Contains 11 references.) (SLD)

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Family to Family

TOOLS FOR Rebuilding Foster Care

Building Support for Innovation Inside Child Welfare Agencies

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A Project of the Annie E. Casey Foundation

Family TO Family
TOOLS FOR
Rebuilding Foster Care

Building Support for Innovation Inside Child Welfare Agencies

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This tool was written by Mal O'Connor, a principal at the Center for Applied Research, Inc.

The Center for Applied Research is a management consulting firm committed to helping its clients learn how to understand, grapple with, and adapt to change. The approaches and tools presented here have been developed by the Center over the course of many years of work in social services in the not-for-profit and public sectors. We are pleased to offer, for their own use, these materials to those working to help children and families lead healthy and fulfilling lives.

We recognize that each child welfare system faces its own unique challenges. The approaches and tools outlined here are designed to help leaders and managers as they work with line-staff, children and families, community members, the courts, and other key stakeholders to develop their own diagnostic and problem-solving techniques within their particular system. As such, these materials are not to be considered as providing specific answers to the particular problem faced by those systems. In addition, these materials have been specifically tailored for use within the domain of child welfare and should not be used outside of that domain.

Many thanks to the child welfare workers, managers, and leaders with whom the Center has worked in Alabama, Maryland, New Mexico, Ohio, and Pennsylvania during the first five years of the Annie E. Casey ***Family to Family*** Initiative. Many of the ideas in this volume, especially those in the four hypothetical cases, emerged from the Center's work with you. In particular, special thanks to Wayne Powell, Cynthia Clark, Vernon Morgan, Chris Humphrey Walker, Carol Schultz, Donna Stark, Judith Goodhand, Paul Vincent, Suzanne Holland, Marsha Wickliffe, and John Mattingly. At the Center for Applied Research, Tom Gilmore, Larry Hirschhorn, and James Solodar contributed many hours of reading and revision time. The Center's editorial staff, Nicole Witoslawski, Laura Gregory, and Sharon Lee, worked diligently to craft the ideas into a readable format. Special thanks to Keri Monihan and Kathy Bonk from the Communications Consortium Media Center for their editorial guidance and production support.

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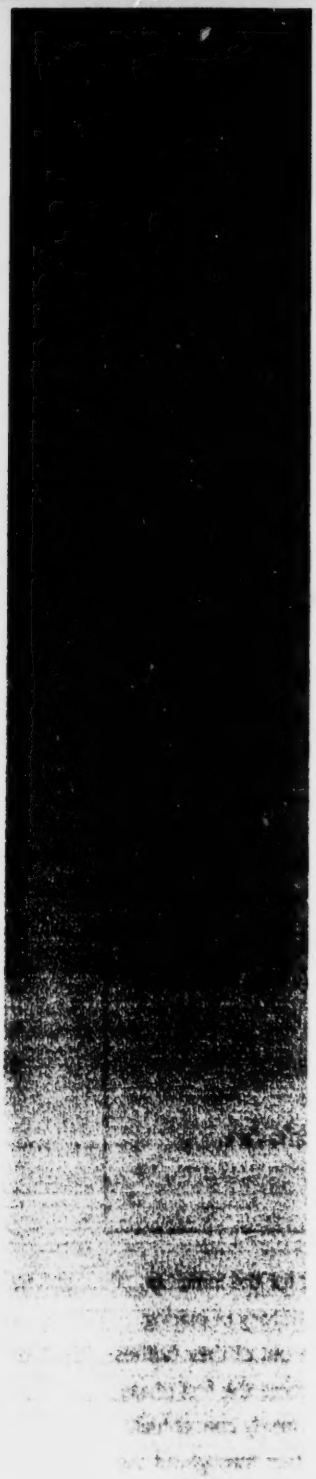

INTRODUCTION

The Annie E. Casey Foundation's Mission in Child Welfare

The Annie E. Casey Foundation was established in 1948 by Jim Casey, a founder of United Parcel Service, and his sister and brothers, who named the Foundation in honor of their mother. The primary mission of the Foundation is to foster public policies, human service reforms, and community supports that better meet the needs of vulnerable families.

The Foundation's work in child welfare is grounded in two fundamental convictions. First, there is no substitute for strong families to ensure that children grow up to be capable adults. Second, the ability of families to raise children is often inextricably linked to conditions in their communities.

The Foundation's goal in child welfare is to help neighborhoods build effective responses to families and children at risk of abuse or neglect. The Foundation believes that these community-centered responses can better protect children, support families, and strengthen communities.

Helping distressed neighborhoods become environments that foster strong, capable families is a complex challenge that will require transformation in many areas. Family foster care, the mainstay of all public child welfare systems, is in critical need of such transformation.

The *Family to Family* Initiative

With changes in policy, in the use of resources, and in program implementation, family foster care can respond to children's need for out-of-home placement and be a less expensive and often more appropriate choice than institutions or other group settings.

This reform by itself can yield important benefits for families and children, although it is only one part of a larger effort to address the overall well-being of children and families in need of child protective services.

Family to Family was designed in 1992 in consultation with national experts in child welfare. In keeping with the Annie E. Casey Foundation's guiding principles, the framework for the initiative is grounded in the belief that family foster care must take a more family-centered approach that is: (1) tailored to the individual needs of children and their families, (2) rooted in the child's community or neighborhood, (3) sensitive to cultural differences, and (4) able to serve many of the children now placed in group homes and institutions.

The Foundation's goal in child welfare is to help neighborhoods build effective responses to families and children at risk of abuse or neglect.

The ***Family to Family*** Initiative has encouraged states to reconceptualize, redesign, and reconstruct their foster care system to achieve the following new system-wide goals:

- ❒ To develop a network of family foster care that is more neighborhood-based, culturally sensitive, and located primarily in the communities where the children live;
- ❒ To assure that scarce family foster home resources are provided to all those children (and only to those children) who in fact must be removed from their homes;
- ❒ To reduce reliance on institutional or congregate care (in hospitals, psychiatric centers, correctional facilities, residential treatment programs, and group homes) by meeting the needs of many more of the children in those settings through family foster care;
- ❒ To increase the number and quality of foster families to meet projected needs;
- ❒ To reunite children with their families as soon as that can safely be accomplished, based on the family's and children's needs, not the system's time frames;
- ❒ To reduce the lengths of children's stay in out-of-home care; and
- ❒ To decrease the overall number of children coming into out-of-home care.

With these goals in mind, the Foundation selected and funded three states (Alabama, New Mexico, and Ohio) and five Georgia counties in August 1993, and two additional states (Maryland and Pennsylvania) in February 1994. Los Angeles County was awarded a planning grant in August 1996. States and counties funded through this initiative were asked to develop family-centered, neighborhood-based family foster care systems within one or more local areas.

Communities targeted for the initiative were to be those with a history of placing large numbers of children out of their homes. The sites would then become the first phase of implementation of the newly conceptualized family foster care system throughout the state.

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The Tools of *Family to Family*

All of us involved in ***Family to Family*** quickly became aware that new paradigms, policies, and organizational structures were not enough to both make and sustain substantive change in the way society protects children and supports families. New ways of actually doing the work needed to be put in place in the real world. During 1996, therefore, the Foundation and ***Family to Family*** grantees together developed a set of tools that we believe will help others build a neighborhood-based family foster care system. In our minds, such tools are indispensable elements of real change in child welfare.

The tools of ***Family to Family*** include the following:

- ❒ Ways to recruit, train, and support foster families;
- ❒ A decisionmaking model for placement in child protection;
- ❒ A model to recruit and support relative caregivers;
- ❒ New information system approaches and analytic methods;
- ❒ A self-evaluation model;
- ❒ Ways to build partnerships between public child welfare agencies and the communities they serve;
- ❒ New approaches to substance abuse treatment in a public child welfare setting;
- ❒ A model to confront burnout and build resilience among child protection staff;
- ❒ Communications planning in a public child protection environment;
- ❒ A model for partnerships between public and private agencies;
- ❒ Ways to link the world of child welfare agencies and correctional systems to support family resilience; and
- ❒ Proven models that move children home or to other permanent families.

New ways of actually doing the work needed to be put in place in the real world.

We hope that child welfare leaders and practitioners find one or more of these tools of use. We offer them with great respect to those who often receive few rewards for doing this most difficult work.

INTRODUCTION TO ORGANIZATION DEVELOPMENT

An Afternoon in Child Welfare

It was late in the afternoon on a Friday, and everyone was looking forward to the weekend when the news came in that a child in our system had died. It was an open case where we had placed the child back in the home after removing her earlier. My phone started ringing off the hook: the local TV stations and newspaper, the hospital and the commissioner were all calling and wanting to know what had happened. We were busy trying to figure it out for ourselves and deciding what we could tell them in the interim.

I used the after-hours staff to try pulling together what happened. It was not easy at first because both the social worker assigned to the case and her supervisor were out on vacation, and most of the files for the case were missing. Members of the staff were sent out to interview the doctors, arrange for the autopsy and coroner's report, talk with the birth parents and police about what they think happened and speak with the foster parents the child had stayed with as well. At this point, we were trying to piece together the history of the case and what lead to the death.

The director was designated to speak to the media. For the moment we had to give the same pat answers. We could not say too much because of confidentiality issues. The media was also hearing from the doctors at the hospital and how they thought that the child should not have been sent home. So, we have to explain to the media again what our policies and mandates are without being able to go into the same specifics as the doctors. It was the hospital that called the commissioner and told him about the death. He is now on the phone with us demanding to know what happened and why he heard from the outside first and not us.

Later the national media started calling, after Connie Chung had talked with the foster parents, and were demanding to know what the policy is for returning children to known abusers and what are the guidelines for determining how much is too much and how could this have happened in America? We still cannot legally comment on specifics of the case. Eventually, the judge who signed the return order will claim that we withheld information, and he never would have agreed to sending the child back to the natural family if he had all the facts.

After some time, the after-hours team pulled together enough information to satisfy the commissioner. The quality assurance coordinator started to assemble the death review team. It is their responsibility to determine formally what happened and assess responsibility.

The social worker and supervisor have been contacted and should be back in town tomorrow. Whether they are reprimanded depends on the report of the death review team. In the meantime, I have to worry about both the staff's emotions and work effectiveness. We have counselors for them if they want, but I am concerned that they will be overly cautious for awhile: less willing to return kids to parents and more likely to pull kids into the system. If we end up having to fire the worker or supervisor, then there might be a backlash against the management, even though we know that the staff is overworked. Additionally, with this hiring freeze in place, we cannot expect to hire replacements anytime soon, which will just make workloads even worse.

All this negative publicity is going to have an effect on our recruiting. More people might be discouraged from volunteering, and I do not know if the news media will give the same free

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publicity for our recruiting events after being frustrated with how little we could tell them.

I'm exhausted.

These sorts of things keep happening. We run around like mad when these crises occur and use up a lot of energy, but that does not seem to keep the same problems from occurring again the next time something awful happens. I need some way to step back and come up with a method of addressing these problems and how they affect our staff, and the agency as a whole, in order to learn ways of responding to them more effectively.

The Current Situation

Many of the pressures facing those engaged in children and family services are not unique to those service providers. Those pressures are part of a much larger social and economic transformation currently underway that has the potential to bring greater dignity to our workplaces and to those we serve while helping us learn how to build a stronger sense of community into our workplaces (Weisbord, 1987). Alternatively, those pressures can cause us to retrench, hunker down and decide to wait out the storm in hopes that "this too will pass." Organization development offers tools and methods for managing the tensions that are part of this transformation by harnessing the energy of the organization and the commitments and values of those who work within it.

A number of external and internal pressures have led child welfare agencies, human services departments, private not-for-profits and others devoted to improving the lives of children and families to engage in organization development efforts. Externally, increasing demands and responsibilities, shrinking resources, and a changing political and legal environment have caused those engaged in child welfare and family preservation to rethink the way they are perceived by the communities they serve. Internally, the need to contain and cut costs, manage turnover rates, use data to manage in the short and longer term, and develop new skills to achieve targeted outcomes have challenged managers to introduce new ways of getting work done with fewer resources.

What Is Organization Development?

What is organization development (OD), and what does "OD" have to do with helping kids and families? How can organization development help address problems like those outlined in the story just told? These are some of the questions we will address in this summary.

Organization development refers to a set of methods and tools for understanding, introducing, managing, and sustaining change effectively over time in order to increase organizational effectiveness.[1] Change, and our ambivalent relationship to it, may be the only constant in our personal lives, the lives of the groups we are members of, and the lives of the organizations we work in.

Organization Development often takes shape as a long-range effort that is planned, implemented system-wide and led from the top to improve a system's problem-solving capabilities and its ability to cope with change. While led from the top, most successful system-wide change efforts do these things well:

- *Connect Vision to Action* – Link OD efforts directly to the achievement of the vision, objectives, and outcomes that the organization must realize in order to improve the lives of children and families.
- *Involve Those Affected by Proposed Change in the Design of the Change Effort* – Include in the design of how best to address and adapt to change those people who will be affected by the specific changes. This takes more time up front, but saves time in the long run. As a colleague of ours says, "Sometimes you have to take the long way around to get there more quickly."

Involve those affected by proposed change in the design of the change effort.

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- ❑ *Expect and Work Through Resistance.* Understand that excitement about, acceptance of, and resistance to change are all integral parts of the change process. Consequently, it is necessary to plan ways to accommodate, incorporate, and respond to waves of resistance to change as part of the work.
- ❑ *Build a Shared Language and Understand and Work with Change.* Work with the entire system over time, building a shared language as well as a common set of tools and methods for managing change. This shared language can become a kind of shorthand for setting and managing expectations.

How Can OD Be Useful to Leaders, Managers, and Supervisors in Child Welfare?

A. Organization development tools and methods can help build a vision that can be shared throughout the agency and the skills needed to put that vision into action to get results.

People can understandably be overwhelmed under the pressure of operating dual organizational structures, under the stress of increasing volume and complexity in workload, all at a time of shrinking resources. One of the primary tasks that leaders and managers encounter is that of helping people contain their anxiety in the face of these pressures in order to focus on the work that needs to be done. We have found that successful leaders and managers have designed their workplaces in such a way that desired goals, outcomes, and accomplishments are clear to all involved and are shared by their staffs.

In some cases, especially in the social services, leaders are pressured to articulate what amount to unattainable goals. Milestones, however, and other ways to measure progress can be clearly identified, measured, and celebrated on the way to what often seems like impossible goals. Work activities can be aligned with those milestones. This kind of shared clarity can in turn free leaders and managers to work more closely with community stakeholder groups, the media, legislators, and others.

To create a workplace where outcomes and the means to achieving them are shared, leaders and managers need to have at least:

- ❑ A shared vision of what counts as success for the organization;
- ❑ A shared understanding of how people, tools, and money can be organized, distributed, and developed systematically to achieve desired outcomes;
- ❑ Enough data to track movement toward (or away from) desired outcomes; and
- ❑ Analytic capacity in the organization to understand and track data and turn it into useful information.

B. Organization development is most useful to leaders and managers when they face the following critical challenges:

- ❑ Keeping the organization focused on a critical few desired outcomes while immediate crises try to replace the important with the urgent.
- ❑ Understanding and addressing the relentless pressures that accompany change; and
- ❑ Managing the volume and complexity of problems and tasks when they increase as a consequence of change.

OD can help provide frameworks for understanding how change works. Novices in understanding how to manage its pressures often react to change as if the issue is about whether one likes change or not, or as if change were in itself positive or negative. Some may say, "I thrive on change," while others might say, "I avoid change like the plague." Comments like these sidestep some critical points: change is inevitable and cannot

Understand that excitement about, acceptance of, and resistance to change are all integral parts of the change process.

be avoided, and we all both engage in and resist change.

Think for a few minutes about the kinds of pressure you face, externally and internally. Make a list without going into detail on any of them. Which are invigorating and necessary to make things happen? Which are frustrating and exhausting and seem to stand firmly in the way of reaching your goals? Which are both? Think about those who report to you: How would they respond to these questions? We have found that it is often one's orientation to change and its accompanying pressure that makes the difference. In some cases it is the fear of what is unknown; in others, it is the sheer volume that becomes overwhelming. In others, it may be the feeling of chaos that comes from loss of enough control, or feelings of incompetence in the face of new challenges.

Understanding one's own orientation toward change can be useful to a leader or manager as he or she begins to build methods for helping themselves and their organizations work with and through change. These methods can act, in effect, as containers that hold the kinds of concerns mentioned above in check. While there is no simple test to discover whether your containment methods are helping or hindering your organization's ability to understand and manage the pressures of change, the following are a few indicators that describe situations where current management tactics are not working:

- ❑ People are asking for more guidance, e.g., questions about vision and direction, and you feel like you have addressed this a million times. You feel like what they are really saying is, "Make these problems go away."
- ❑ While you may wish that others would handle problems, most final decisions still end up on your desk.
- ❑ Individuals are working harder than they ever have before but are not getting all of their work accomplished. Some people coming in at the case-worker level are initially excited, but quickly burn out and leave after only a few months on the job.
- ❑ You continually try to create an atmosphere of collegiality and open discussion, but it seems that the most genuine discussion occurs not during your meetings but in the hall. During one-on-one supervision sessions, you either hear that everything is fine or that the problems your direct reports face are primarily about their prior personal history with others.

OD can help you move toward a different set of indicators:

- ❑ People recognize how their function impacts other functions, and how all the parts fit together in ways that move the whole agency forward. Consequently, people know when to work alone and when to collaborate in teams, within a unit and across functions.
- ❑ Fewer decisions come to you for final approval unless you have negotiated with others for that role.
- ❑ Supervision sessions work both ways: you coach your direct reports and ask for and receive feedback about what you could do more of, less of, or the same to make your direct reports more effective.
- ❑ People throughout the organization have moved from asking you to "make these problems go away," to inventing ways together to manage ongoing dilemmas that are here to stay, at least for a while.

*C. **Organization development can help build a new system while still retaining the best features of the old one. We used to think about this as building a bicycle while riding it, but it now feels more like building a rocket ship while launching it.***

Organization development can help build a new system while still retaining the best features of the old one.

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*Some child welfare agencies began to think about **Family to Family** less as "more work to do" and more as "a way to get work done."*

Many organizations faced this problem when grappling with how best to fold the ***Family to Family*** principles into their work. ***Family to Family*** was designed as a set of outcomes that targeted changes in foster care. In most cases, the first approach to ***Family to Family*** was to create a separate organizational structure that paralleled the existing one, often in the form of a separate unit that experimented with ways of reaching ***Family to Family*** outcomes as a pilot project. This usually resulted in the creation of simultaneous, dual-service delivery systems: an older system that continues to do its work while a newer system begins to take shape at the same time. They are often set up as opposites, one good and the other bad. However, most organizations, including child welfare agencies, find themselves in a process of continuous reinvention. There is a continuous tension between needed innovation and existing programmatic ways of doing business.

The positive aspect of the dual-service delivery system approach was that one could use a test site or unit to learn how to introduce and implement ***Family to Family*** without committing too many resources to it all at once. The upside of "pilots" is that change efforts often need a protected phase at the beginning to learn how new ideas will be received in a particular organizational culture. The downside of pilots is that they do not really address what will happen when going full-scale, organization-wide. In addition, using a pilot approach pulls resources away from what many see as the primary work of the organization, i.e., making the old system work. In this case, kids were still streaming into the old system at the same time that staff were being pulled away from "the real work" to take on apparently lighter workloads on ***Family to Family*** units.

Over time some child welfare agencies began to take a different approach. They realized that principles and methods used to reach ***Family to Family*** outcomes affected the entire system of which foster care was a critical part. They began to think about ***Family to Family*** less as "more work to do" and more as "a way to get work done."

When leaders and managers think about introducing ***Family to Family*** as a way to get existing work done differently, and more effectively, the work is no longer about operating two systems at the same time. Instead, the entire older system is examined in light of a new lens using ***Family to Family*** principles and methods, keeping what works and replacing what does not with new methods of working. The ***Family to Family*** method emphasized, for example, gathering and analyzing data over time and using it to manage and make decisions; building stronger relationships with the community and the media; and working in new and different ways with clients, peers, subordinates and superiors.

In other words, some child welfare organizations reframed the problem of dual overlapping systems into an opportunity to initiate and manage change. Instead of creating an "either-or/old vs. new system" decision, they focused on using ***Family to Family*** principles and methods to change practice – from the front line to the top of the organization and back again. Their work has been by definition incomplete and messy, but the change in approach marks a critical step in organization development. We offer a number of tools for understanding and implementing this integrative approach to managing change in the pages that follow.

How Can Organization Development Tools Be Used Effectively in Child Welfare?

Simply providing a toolbox full of organization development tools would not be helpful. It is important to know how to select the right tool for the job. As a famous philosopher once said, "When all you have is a hammer, the whole world looks like a nail, including your thumb." In order to help with the selection process, we first introduce a way to think systemically about organizational problems and dilemmas. Systems thinking is useful both in understanding and addressing organizational problems in ways that connect each person's part to the whole picture. An intake unit, for example, can cut its response time down to just a few hours, but if the Child Abuse and Neglect and Foster Care units cannot handle the incoming caseload, the system may fail. Thinking systematically can help with problem identification and indicate where it would make most sense to focus time and attention in order to address those problems. Systems thinking is itself a tool.

The systems thinking section is followed by a series of case studies that use systems thinking to identify and understand organizational problems and introduce tools that can help address them. The cases are built on experiences we had working with child welfare agencies and state departments of human services as they introduced ***Family to Family*** principles into their work. In each case, tools appropriate to that case are identified and introduced in ways that show how that particular tool can be used to address a particular problem. A formal description of each of the tools used follows each case.

SYSTEMS THINKING – A TOOL FOR CHILD WELFARE

Introduction to Systems Thinking

A system is composed of a set of parts, or subsystems, that together form a complex whole. All organizations are systems, but we often forget this in the midst of crises. When problems occur, our attention is often diverted to the particular part of the system where the problem appears. We imagine that if we fix the part, the problem will be solved. In the process we often confuse the symptomatic presentation of a problem with its cause. Consequently, the same kind of problem occurs again and again, as in the description above of an afternoon in child welfare.

Systems thinking provides a way of understanding a complex set of relationships, made up of a number of interdependent parts, as a discrete whole, with a distinct boundary that separates the whole system from the rest of the world.[2] A child welfare agency enacts this set of relationships every day. Internally, the agency struggles to get each of its parts to work effectively as a whole system. Outside the agency, the community, the courts or the media may look more at the system as a whole, and less at its parts, as they assess the results of the agency's work. They often hold the agency as a whole responsible if a child is brought into care prematurely, or sent home before parents have the skills to care for the child, and a tragedy occurs.

The success of any system is dependent not only on having the correct parts, or subsystems, but depends on the *relationships* between and among the parts. We often think that we understand a system when we understand its parts, but we have only just begun. Systems are about the relationships between the parts. The parts need not only to be running properly and efficiently in their own environment, they need to be cooperating with each other properly as well.[3]

Think of a car. A car is a complex system made up of a number of subsystems. Included in those subsystems are the frame assembly, the ignition system, the braking system, the engine system, and so on. Each of these could be thought of separately as a system itself, but each of these subsystems needs to work efficiently in relation to the others in order to enable the car to operate effectively. In other words, no one of these subsystems by itself could make the car move. Each subsystem is a necessary, but not a sufficient part of the complex whole we call a car.

Consider a child welfare agency as a system. There are certainly numerous subsystems at play: investigation, intake, child abuse and neglect services, foster care, counseling services, case work, administration, etc. There is a great deal of interdependence between and among the parts. A complaint is made to the department, an investigation is undertaken, a case worker is assigned to the case, she assesses the situation and has the child removed from the home, the child goes to a foster family, and so on. Each of these actions involves a different part of the child welfare system. It is, therefore, vital that these components coordinate their efforts effectively and efficiently. Just as the car breaks down if the radiator overheats, the services delivered to the community suffer if any component of the social welfare system or interaction between components breaks down. *Systems thinking is a tool that can be used to assess whether break downs have occurred, determine where the source of the problem is, and work to resolve the issues.*

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We are often ambivalent about thinking systematically, confusing parts for wholes. Take the food system where I live, for example. I used to think highly of myself because I was always willing to "help" around the kitchen. I would do the dishes, or I would help chop vegetables for soup or salad, and so forth. My spouse was always less than thrilled, but I thought I was "doing my part." The problem was that I was only looking at some of the parts, and assiduously avoided learning about how the parts worked in relationship to each other and to the whole home-food system. For example, the whole home-food system includes "intake" from a number of sources, requires knowledge and expectations about meal planning as well as knowledge of what is still dead or alive in the back of the refrigerator, cupboards, etc. In addition, there is the "maintenance" subsystem, that includes preparing, cooking and cleaning up after meals, and so forth.

Once I understood there was a system, I could begin to see how all the parts of that system worked interdependently to ensure that we were eating well. I could also see that I was working in some parts of the system, and simultaneously avoiding understanding the system as a whole. Why? I did not want to take on what we call the "work of worry" about the whole system. I wanted that responsibility to lie elsewhere. I would just do my part and ask my spouse to worry about her parts *and* the maintenance of the whole system. However, I still wanted to reserve the right to complain if we were spending too much money eating at restaurants.

Most leaders face similar dilemmas in managing child welfare systems. They are responsible for a whole system, which is at the same time a subsystem of a larger system. From a systems thinking point of view, this role comes with an attendant set of problems, including:

- How to build an understanding among managers and supervisors about how each part fits into the whole system in order to help them achieve the kind of outcomes that will help everyone make the whole truly greater than the sum of its parts.
- How to best spread across managers and supervisors the "work of worry" about the system as a whole.
- How to create a climate that encourages people to pay attention to feedback and to learn from failure without fear of retribution.

We find it is helpful to focus on a few key concepts in order to begin putting systems thinking to work. They include:

1. Diagnosing Part-Whole Relationships: Vicious and Virtuous Cycles
2. Managing Boundaries
3. Continuous Learning Through Dialogue and Feedback

Diagnosing Part-Whole Relationships: Vicious and Virtuous Cycles

When thinking systematically, it helps to think of work as sets of activities flowing through the system. Often in human systems, different parts of the system are able to move work through at different rates. The processing of foster children, for example, may happen much faster than the ability to get them placed into actual foster homes. In such a case, placement is referred to as the "rate-limiting step," or "constraint," in the system. It will not matter how quickly the upstream work that leads to referrals is being done if there is a bottleneck downstream. The flow of work will pile up when it hits referral. We often attribute problems that result in bottlenecks to people and their ineffectiveness. Systems thinking teaches us to examine the problem systematically first, and then decide how much of it is attributable to specific people.

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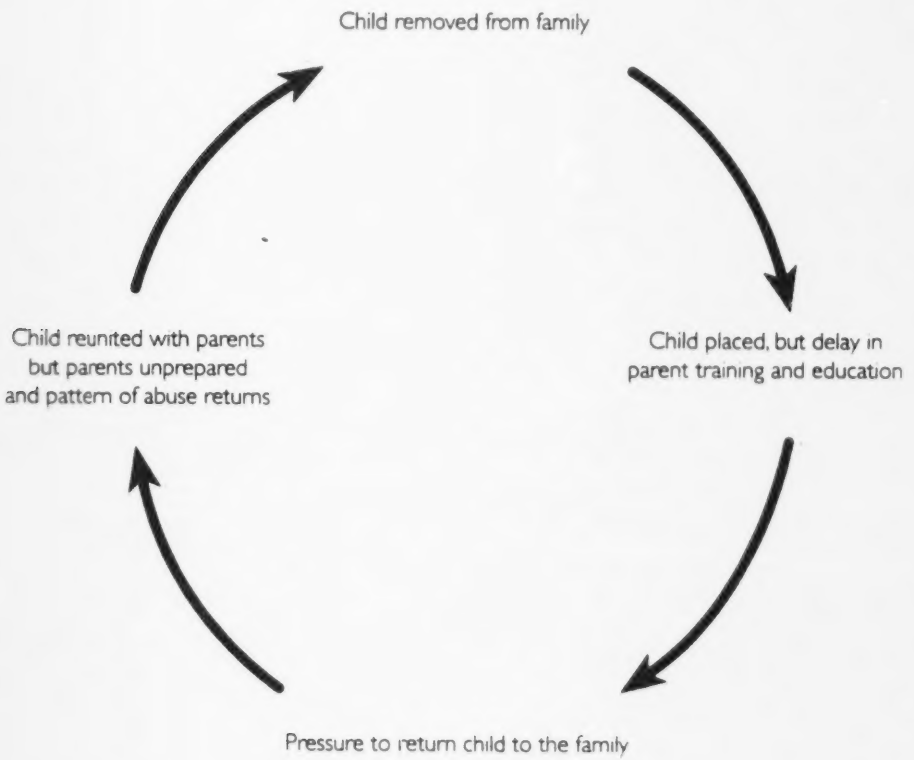
Once identified, the cause of the constraint may be uncoupled and examined. Sometimes parts of the system can be improved and the limitation removed or lessened. Other times, perhaps due to outside pressures, the functioning of a particular part of the system cannot be improved. At this point, identifying and understanding the constraint can be used to adjust the parts around it to help work flow in ways that do not put too much pressure on people in any one part of the system.

For example, a weak link in many social service systems often occurs on the boundary between service providers and parents. Frequently, the focus is on returning the child to the family quickly and not on addressing the need to improve parenting skills in the home. As a result, the child often ends up back in the care of the system and the family has lost an opportunity for improvement.

Moreover, when this happens the agency may have lost some standing in the eyes of the community and may be seen as something of a revolving door. Here, the apparent goal of returning the child to the family can stand in apparent conflict with the broader goal of providing a better home environment for both the child and the family.

A systems thinking approach would ask, "Is the particular crisis that occurred today part of a larger pattern of activity that occurs repeatedly? Let's look at the relationship between the different parts of the system involved and examine the pattern of activity that occurs time and again, rather than assigning blame to particular people at this point." One way to do this is to draw the sequence of events as they occur. They often run in cycles. For example, in the case above we could draw the sequence as follows:


Child removed from family
Child placed, but delay in parent training and education
Pressure to return child to the family
Child reunited with parents but parents unprepared and pattern of abuse returns

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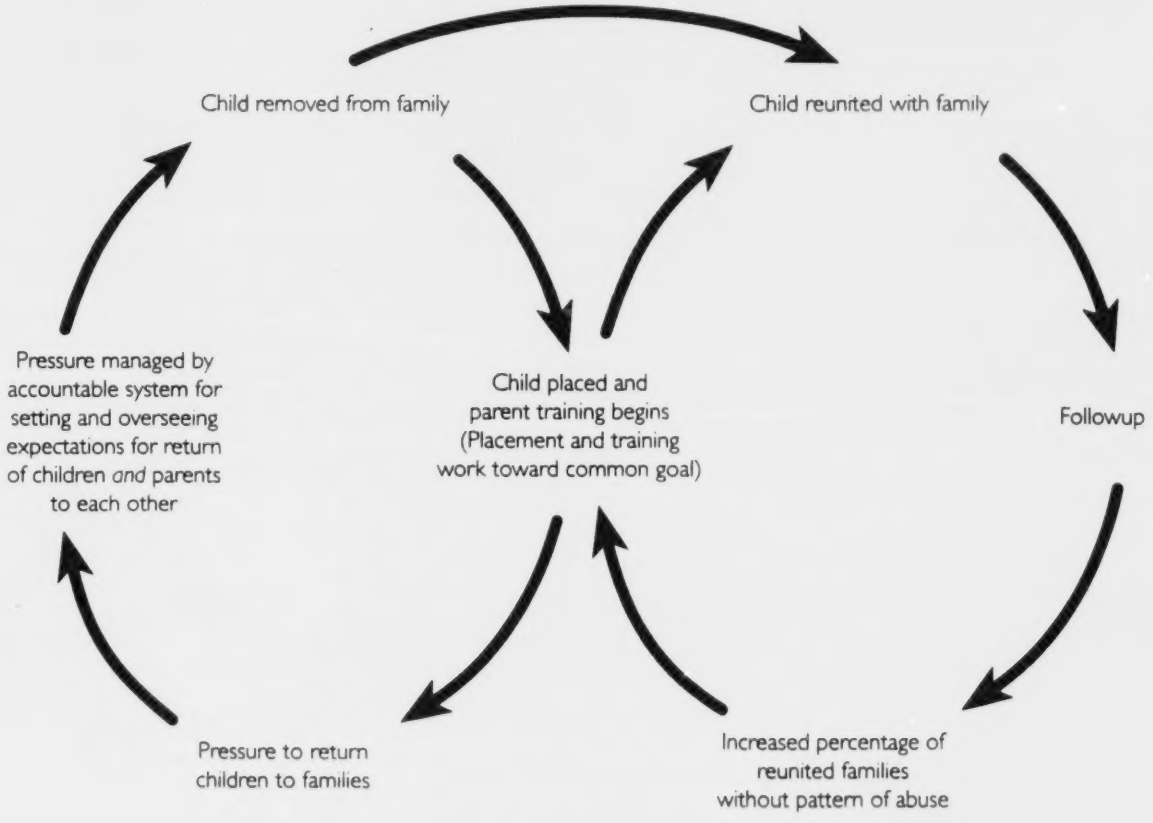
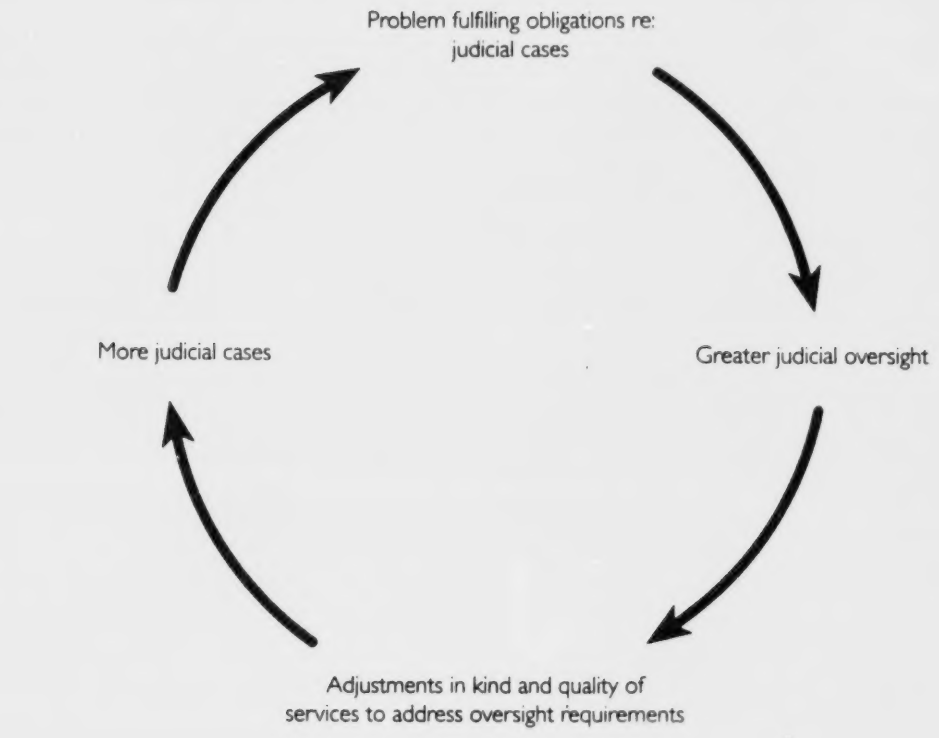
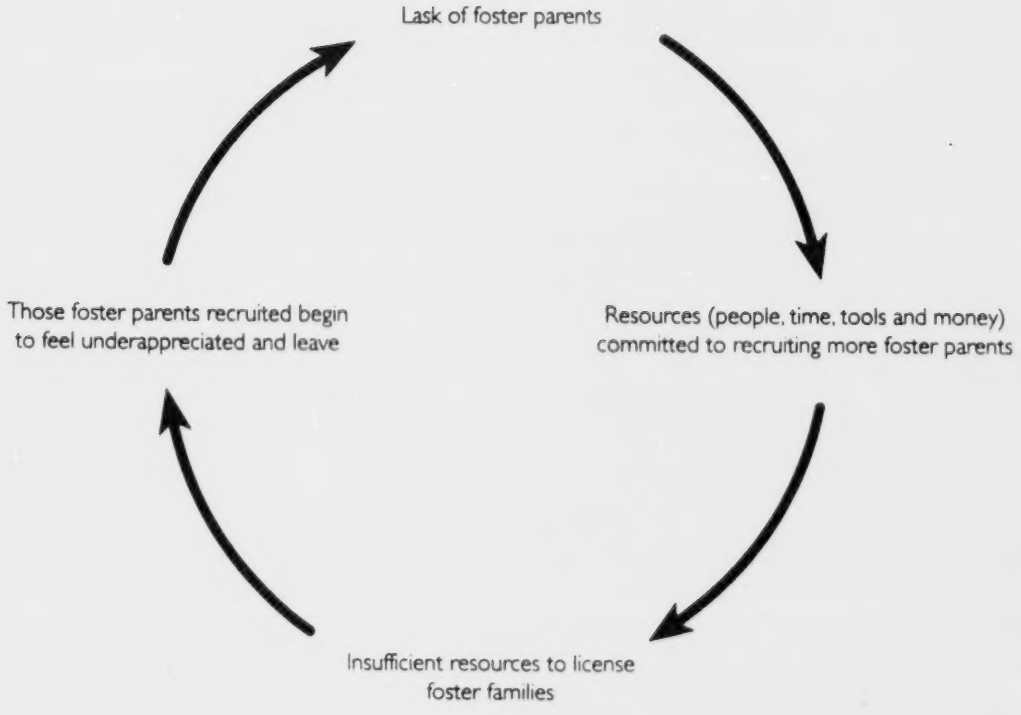
We call this kind of pattern a vicious cycle. One goal of any organization is to achieve desired outcomes by identifying vicious cycles and turning them into virtuous ones. Drawing this cycle could help identify which parts of the system are dependent on each other, in this case placement and training at least. Each could, perhaps, make a case that their part functioned well, and yet the system as a whole could fail if its larger goals are not well understood by all the parts. Working within each part and between them could help achieve an outcome that would keep children reunited with their parent(s), and consequently reduce the rate of return of the same children into the system, thereby reducing the stress on other parts of the system as well.

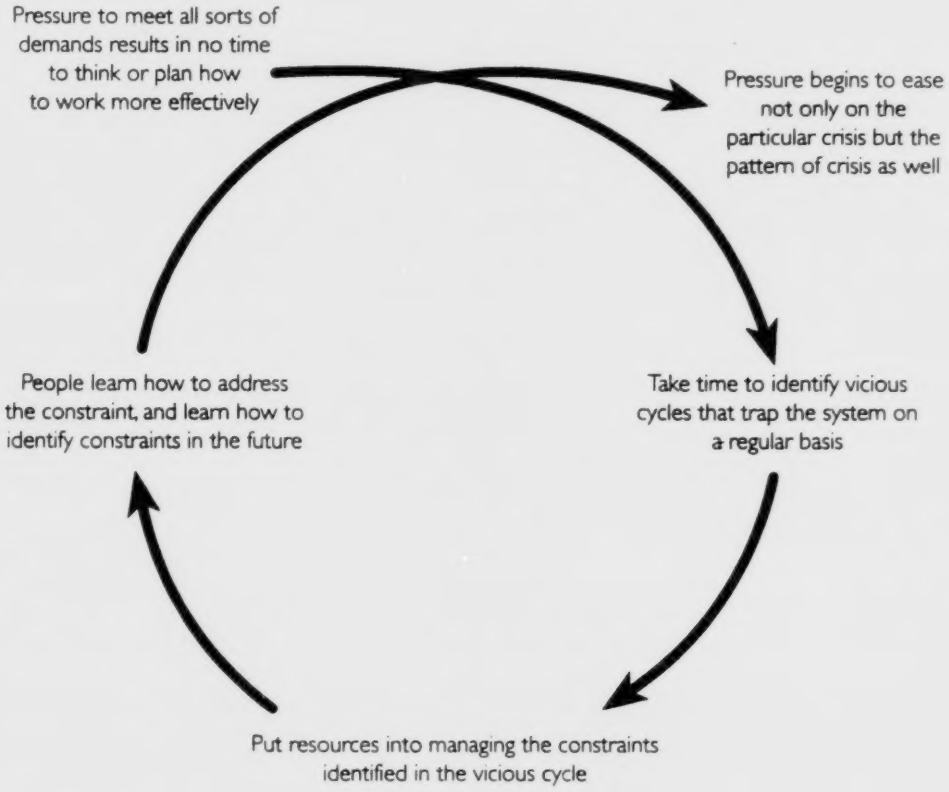
A virtuous cycle in this case might look something like this:


Child removed from family
Child reunited with family
Pressure managed by accountable system for setting and overseeing expectations for return of children *and* parents to each other
Child placed and parent training begins (Placement and training work toward common goal)
Followup
Pressure to return children to families
Increased percentage of reunited families without pattern of abuse


Problem fulfilling obligations re:
judicial cases
Greater judicial oversight
Adjustments in kind and quality of
services to address oversight requirements
More judicial cases


Lask of foster parents
Resources (people, time, tools and money)
committed to recruiting more foster parents
Insufficient resources to license
foster families
Those foster parents recruited begin
to feel underappreciated and leave

Frequently, managers and leaders are so pressed to manage crisis by crisis in order to keep the dike from bursting that it is difficult to find the time to identify vicious cycles and transform them into virtuous ones. Paradoxically, it is the time spent doing so that can help everyone in a social service agency learn how to avoid making the same mistake over and over again. This in turn can create space and time to work on other urgent issues. Here is a virtuous cycle representation of this process:


Pressure to meet all sorts of demands results in no time to think or plan how to work more effectively
Pressure begins to ease not only on the particular crisis but the pattern of crisis as well
Take time to identify vicious cycles that trap the system on a regular basis
Put resources into managing the constraints identified in the vicious cycle
People learn how to address the constraint, and learn how to identify constraints in the future

Unlike a vicious cycle, which continues to spin in the same place, a virtuous cycle can help build momentum and movement toward a set of outcomes. As a diagnostic tool, vicious cycles focus on the flow of work, and how to design that flow to achieve better results. Individual development and skill improvement are certainly valid goals as well. However, in an attempt to identify and improve vicious cycles, focusing at first on individual behavior will distract participants from the underlying patterns of the cycle. It helps to begin with the flow of work. Then, after designing systems that should function more effectively, address whether individuals are performing as expected. This helps create a climate in which those who are responsible for doing the work can participate in improving its design and execution without fear of retribution.

Managing Boundaries

In tightly coupled systems like child welfare agencies, most constraints are found on the edges between one part of the organization and another. If we think about work as activities that flow through the system, handoffs from one part to another become critical junctures. We refer to those transfer points as boundaries. Boundaries can act as permeable membranes

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through which information passes freely, or as impermeable walls that stand in the way of collaboration toward critical goals and objectives. In a child welfare agency, for example, boundaries lie between functions such as investigation, intake, child abuse and neglect, and foster care. Boundaries also exist across hierarchical levels, e.g., between a director and his or her program managers, managers and supervisors, or supervisors and case workers.

Boundaries are not just lines on an organizational chart. They are places we create everyday where work, information, and the expectations about the quality of care are transferred from one person or group to another. They are places where people negotiate with each other to determine what they will and won't do to meet not only the needs of their part of the system, but the needs of the system as a whole.

We think of boundaries as geographical spaces that are created by people as they work with each other to decide what needs to be done about an abused child, to determine caseload distribution, to change the way two units are working together, or to ensure that core values agreed upon at the top of an organization are shared and acted on as service is delivered to clients.

Repercussions will not necessarily appear where the problem is occurring.

The boundary between a system and its external environment is critical as well. In the case of social service agencies, those on the other side of the boundary include community groups, the judicial system, the media, and others who have a stake in the work of child welfare organizations.

The ways in which internal boundaries are managed affect how external boundaries, such as those with the community, are managed. When citizens call to report a problem, do the people they speak to give an impression of being knowledgeable, competent, and comprehensive? When the social worker goes into the community, is she seen as professional, assured, and competent? Is the response time between a call being placed to the organization and a social worker following up reasonable? While some of these activities appear to be internal, each occurs on the boundary of the organization with its external environment.

The answers to questions like these will greatly influence the degree to which the community sees an agency as a place where help can be found, and the degree to which the agency is regarded as ineffectual and unhelpful. Systems thinking can help you differentiate where the problem is located from the symptomatic way it comes to your attention. In other words, the repercussions will not necessarily appear where the problem is occurring. The percentage of children coming into the system with severe injury may increase, not because the rates of abuse are changing in the community, but because the members of the community have come to the conclusion that the system is unresponsive to minor cases, and so the call is not placed and intervention does not occur until the case becomes serious.

When beginning to identify and work with boundaries, we recommend thinking of each unit as a team. Some parts of each unit's work will focus internally and other parts are likely to focus externally, e.g., on building relationships with community groups. Each team should be able to answer questions like these:

- ❑ Why are we doing this work? What is our contribution to the whole system? What is the part we play?
- ❑ What is our task(s)? What do we do that gives us our identity and differentiates us from others?
- ❑ What mix of skills do we need to do this work? What is missing?
- ❑ What are we accountable for, and to whom are we accountable?

- ❑ What assumptions do we make based on what we do vs. what others do? Whom do we include in our team? How many other teams are there?
- ❑ What do we need from other teams that would make our job easier, and what do they need from us?

We often assume that all team members agree about what they are supposed to do, but understandings may vary widely among its members. Taking the time to come to a negotiated agreement as a team in response to the questions above is a giant step in itself.

After establishing a common understanding of the roles and responsibilities of the various teams within the system, you can look at the flow of work across teams/units/functions. Boundary management questions will immediately come to the fore: Are the foster parents sufficiently trained to handle the strains we ask them to? What are the key boundaries they need to manage? Are they supported by other parts of the system in ways that help them meet their objectives? Are the file and data systems unified across teams so that everyone has access to the full information about a case? Do the relevant case workers have enough time to be available to testify at the court cases that develop without the rest of their caseload suffering?

Often the most productive problems are found on critical boundaries, while investigating misunderstandings, mistakes, or insufficient exchange of information between teams. Investigation often reveals not only a one-time problem, but a systemic constraint that contributes to a vicious cycle. When this happens, mistakes and problems can become genuine learning opportunities that can help turn a vicious cycle into a virtuous one.

Continuous Learning Through Dialogue and Feedback

It is easy to say that mistakes offer rich opportunities for learning how to improve performance. It is very difficult, however, to create a climate where managers and employees actually believe this is possible, a climate of respectful, direct talk without recrimination. Systems thinking tools can help you create this climate in a number of ways. They do this by:

- ❑ Focusing first on analyzing workflow and the relationship of parts of the organization to the whole enterprise, rather than immediately placing blame on individuals in the part of the organization where the problem appeared.
- ❑ Creating opportunities to learn by doing – what we call "action learning."
- ❑ Encouraging continuous learning through dialogue and feedback, when things go wrong as well as when they go as expected.

We used a car analogy earlier to describe a system. A car is an example of a mechanical system. Cars are not capable of both diagnosing and repairing themselves, at least not yet. Human systems are not simply mechanical, they are purposeful, or transformational as well, i.e., they have the ability to change.[4] We have the ability to diagnose and address problems as they arise and transform ourselves and our organizations in the process.

To transform themselves, human systems rely on the ability of their members to learn. Much of the opportunity for learning occurs when and where things break down, which, as discussed above, is often on the boundaries between the parts of the system. It is a management truism that it is important "to catch people doing something right." Yet fruitful learning comes from direct talk and feedback about things that have not gone as expected as well. This is especially true in times of rapid

Investigation often reveals not only a one-time problem, but a systemic constraint that contributes to a vicious cycle.

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Systems thinking tools can help provide a climate of safety in which to work with mistakes as critical data in the diagnosis and management of organizational dilemmas.

change, when it is critical to discover if what a leader or manager has said is what was heard in the way it was intended and when it is critical to get feedback from the frontline in order to know if one is leading in ways that help those in the middle and on the frontline deliver the kind and quality of service the organization stands for.

Our understanding of how the relationships among the parts of a system are working comes from feedback. To use the care analogy one last time, the indicator light on the dashboard gives us feedback that we can choose to use or ignore about the radiator overheating. If the radiator overheats, the engine will shut down and the car will eventually stop moving. In human systems productive feedback often comes from failure indicators as well. However, we often look at failure as a particular person's fault, or at the failure of one part of the system, thereby missing the opportunity to learn and adjust based on the feedback provided about the system as a whole and the relationships among its parts.

We often shy away from examining mistakes, especially in a field like child welfare where the lives of children hang in the balance. This is a logical response to the kinds of serious and recalcitrant problems faced by child welfare workers everyday. However, this kind of response can doom us to relive the same problem again and again. Our immediate response to mistakes, which often appear in the form of crises, is to react and patch up the particular crisis as quickly as possible in the short term, and move on to the next one. We need to protect ourselves in order to continue to work in such a volatile environment. It can be painful to revisit mistakes, especially when another crisis is looming. Systems thinking tools can help provide a climate of safety in which to work with mistakes as critical data in the diagnosis and management of organizational dilemmas.

Systems Thinking – Implications for Action

Systems thinking does not change the primary task that managers and leaders in social welfare face, i.e., the task of creating a context in which desired outcomes for children and families can be reached. However, it can help you differentiate between being responsible for creating the context or conditions for success and doing it all yourself. Recall the problem of the leader for whom too many decisions wind up back on his or her desk after he or she thought they would be handled by others. Systems thinking encourages leaders and managers to:

Create a Shared Vision

If the whole is to become greater than the sum of its parts, the parts need to be involved in creating the whole – in this case represented, for example, by the vision of the agency. This is very different than believing that one person at the top is responsible for the vision and everyone else for executing it. Including others throughout the organization does not mean, however, that the vision is up for grabs. A leader and his or her top team need to set the parameters within which the vision is created, including any constraints posed by forces beyond your control.

One of our colleagues, Marv Weisbord, calls this "bringing the whole system into the room." Buy-in is created when those responsible for executing the work are involved in its design. Depending on the size, the complexity, and the particular demands faced by your organization, you can do this over time in layers, or work with the entire organization in a large group. *(See Building a Shared Vision and Setting Priorities for further information.)*

Use the Hierarchy Effectively

Some people imagine that if hierarchical command and controls disappeared, everything would work more smoothly. However, it is often not the hierarchical role system that is at fault, but the way it is deployed. Hierarchies can be well suited to child welfare settings when managers and leaders do not confuse their responsibilities with those of the people who report to them. This tends to occur when those who have been successful as social workers are thrust into managerial and leadership roles, and it is believed that they will be successful managers because they were successful social workers.

Managers face different challenges. One of the most important is the challenge of building effective working relationships where expectations are clear and aligned with an agreed upon set of outcomes. Systems thinking can help you build these working relationships by opening up channels for learning and feedback where none existed before. Once those channels are open, systems thinking tools can help you manage the boundary relationships between the units and/or divisions you are responsible for, and help you coach those who report to you about how to build teams of their own. Systems thinking tools can help you distribute work effectively, and hold people accountable by negotiating mutually agreed upon goals. They can help you build teams that work cohesively as you focus on the relationship between the parts. Perhaps the greatest challenge is to devote time and attention to these tasks while being pulled in other directions by the latest crisis. *(See cases and tools on Building Effective Working Relationships for further information.)*

Build a Learning Agenda for Yourself and Your Team

In a world of continuous change, staff turnover, cost containment, drug addiction, and pressure from the media and other external forces, it is not easy to make the time to learn new skills. The alternative may, however, be another turn on the vicious cycles that seem to create more and more work to do in less and less time. One of our responsibilities as managers and leaders is to create the space and time to help members of our organizations develop ways of working effectively in a continuously changing work environment. Easy to say and difficult to do.

One way to start is to build a learning agenda for yourself. What do you need to learn to be more effective in your role? Take the time to meet with your team to build a learning agenda with them. Identify the problems you face as a system. Systems thinking can help you diagnose those problems and decide which are fixable and which are constraints that need to be managed to make the rest of the job possible. You will be building the strength of your team as you do so.

Next, work with your team to strengthen the project management skills needed to tackle those problems. They may be deciding how to divide up the work or who should be responsible for what. They may concern building a new system while maintaining the old one. Decide who needs to be in the room to do the diagnosis needed as well as solve particular problems. Decide what data you need to track your work and to support decisionmaking in the short term and the longer term. Create a path that begins with the end you want to achieve and works back from there to determine the work needed as well as the resources it will take to reach your goal. *(See Creating a Framework for Managing Projects for further information.)*

Systems thinking tools can help you distribute work effectively, and hold people accountable by negotiating mutually agreed upon goals.

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INTRODUCTION TO ORGANIZATION DEVELOPMENT TOOLS

The section that follows introduces a number of tools that can be useful to those facing the challenges of managing and leading child welfare organizations in turbulent times. Rather than simply list the tools, they are introduced within case studies in which they were used to address particular problems.

The case studies grow out of our work with the ***Family to Family*** grantee states. In each case particular organizational problems are introduced along with tools that can be used to address those problems. In our work with the grantee states, we found that many leaders and managers were very creative in their use of OD tools. They discovered that the value of the tools does not lie in the tools themselves as much as in the way they are used.

There are four case studies. Following each case study the tools used in that case are described in detail. Each summary outlines when and where to deploy a particular tool, as well as a step-by-step method for using it effectively.

- ❑ Case Study One – Building a Shared Vision and Setting Priorities: A New Leader's Story
  - ■ Tool A: Guiding Principles
  - ■ Tool B: Approach to Ranking Priorities
- ❑ Case Study Two – Building Effective Working Relationships: A Program Manager's Story
  - ■ Tool A: Responsibility Charting
  - ■ Tool B: Role Negotiation
- ❑ Case Study Three – Getting Task Forces Started: A State Director's Point of View
  - ■ Tool A: Task Forces: Beginning the Work
  - ■ Tool B: Driving an Initiative
  - ■ Tool C: Defining, Clarifying, and Confirming the Task of an Initiative
- ❑ Case Study Four – Creating a Framework for Managing Projects: A Mid-level Manager's Viewpoint
  - ■ Tool A: Stakeholder Mapping
  - ■ Tool B: Communicating
  - ■ Tool C: Using a Meetings Map
  - ■ Tool D: Building a Meeting Cycle

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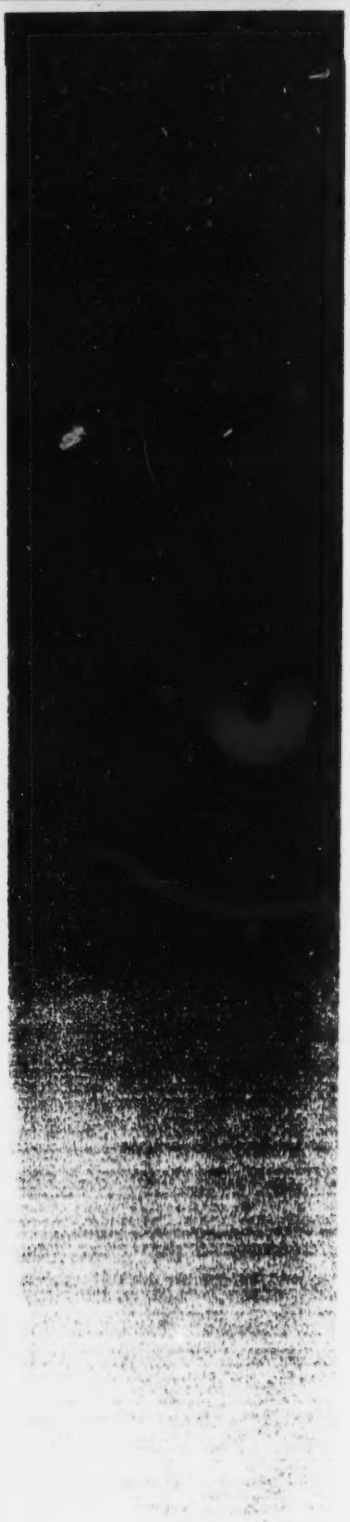
In order to provide greater relevance to a variety of child welfare settings, each case study is written from the point of view of a leader or manager in child welfare, and each is written from a different point of view. Those points of view are as follows:

Case Study	**Perspectives**
Case Study One – Building a Shared Vision and Setting Priorities	New leader of a county social services agency
Case Study Two – Building Effective Working Relationships	Program manager of a child welfare agency
Case Study Three – Getting Task Forces Off the Ground	State director of a statewide reform initiative
Case Study Four – Creating a Framework for Managing Projects	Mid-level manager in a social services agency

For those interested in further discussion of organization development tools and methods, we have included a selected bibliography of readings that more deeply explore OD in a variety of settings.



CASE STUDY ONE– BUILDING A SHARED VISION AND SETTING PRIORITIES

Task

As a new leader entering the organization from the outside, I knew what I had to accomplish: stabilize the organization, forge stronger working relationships with judges, the community and the media, reduce time from investigation to intake, and improve outcomes for kids and families. I knew I could not do this by myself. I needed a vision that everybody could join in and sign up for, an agency where each person could understand how their part or position contributed to achieving that vision. I knew what I wanted; the question was how to get there. I could tell people what to do, but I had been down that road before and knew that if people just mouthed my ideas, it would not work.

My tasks were numerous. First, I had to figure out what I wanted as outcomes and give people some guidelines within which to create the vision – to be honest about what was in bounds and what was out. Second, I had to help guide the organization in constructing our vision while keeping my own mind open, based on how the work unfolded. Third, I had to make sure our vision was focused on the challenges we faced and not only on ourselves. It would be vital, for example, to not just have an internal vision of how our organization would work but also how we would relate to and work with the outside world.

Setting

We were working within the constraints of a consent decree that required us to radically change the way we worked, while still living with the existing system that we had in place. With caseloads at historically high levels and a hiring freeze imposed on us, staff morale was at an all-time low and it seemed like every decision ended up back on my desk. Files were missing, and our relationship with key judges was strained due in part to neglect, late filings and the like. The newspaper was blaming us for everything imaginable, while the state department thought we were being mavericks, intentionally out to rock the boat.

At the same time, the majority of our managers, supervisors, and caseworkers were very dedicated people. They were simply overwhelmed. We had a backlog of cases that resulted in long delays in getting children into the system. It seemed that as soon as new caseworkers were trained, they would be lured away by another job with better prospects. The frustration created friction internally, and people hunkered down within their units, blaming others for delays, and not wanting to take on anything "extra." As a result, handoffs from one unit to another were strained, and it was the kids who started falling through the cracks.

What We Did

I called a meeting of the leadership team and asked them to think with me about how we could build a vision of what we wanted to see in the future rather than a laundry list of all the problems we faced today and why they are insurmountable. They needed time to vent before we could do that, so we began focusing on the vision at our next

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meeting. This was clearly going to be a process not a project, and we would need a series of gatherings to accomplish the task. We set up a three-meeting cycle to outline a process for building an agency-wide vision.

When we met the second time, I learned two things: first, that I could not facilitate and participate in the work at the same time, it was too confusing. Second, my leadership team was a group of dedicated individuals, not a team. Each member had become so consumed by individual responsibilities and the pressure of daily crises that they had not been able to focus on how each part fit with the other parts of the system. They had assumed I would handle all of the integration work. No wonder so many things were ending up on my desk. Their direct reports probably made the same assumptions about them that they made about me. When in doubt, push it up.

We asked an outside consultant with whom people had some prior experience to help us. That enabled me to take on a different role at our meetings. We decided that, as the people responsible for the well being of the organization, we needed to get our house in order before asking the rest of the organization to participate. We would be abdicating our responsibility otherwise.

At the same time, we put a time limit on the work of forging a team because we wanted to build our vision with the rest of the agency and not present something pre-cooked to them. We used ourselves as a pilot experiment. Our goal was to design a method for working with the entire agency to build a shared vision of the future, and we had to be able to work with each other first.

We decided that we faced a double task: to outline a vision and to set priorities for how to achieve it. The vision, therefore, had to be doable. Our first attempts at articulating a vision were abstract and disconnected from our everyday work. We decided to begin by describing *how* we wanted to work together. Then we could decide what outcomes we wanted to reach and how to reach them. We realized that our specific tasks would change over time. If we learned how to work together, we knew we had the expertise and the will to get the work done.

We had talked ourselves down almost every possible road in the past. So, we chose not to begin with a general discussion, but instead ask each member of the team to draw two pictures: one of their vision of the work of the organization as a whole, and the other of how we could work together to accomplish it. This felt awkward at first, but turned out to be a very powerful piece of work. It was surprising how different some of our impressions and insights were. This was the starting point for an unusually open discussion of our visions of the organization. The drawings allowed each of us to reveal assumptions, hopes, and points of view that had been difficult to put into words. Then, as we drew each other out in our discussions about the drawings, we discovered things about our own and others' perspectives that we had not articulated before.

We took our time working through the drawings and came up with a set of "guiding principles." (See Tool A: Guiding Principles that outlined the criteria for how we believed the agency should work and how we wanted to work together to make that happen.) These guiding principles included:

- ❑ Everyone is here to work together towards the same goals of helping kids and families.
- ❑ All ideas deserve a fair and open hearing.
- ❑ Outside of this room we all stand together behind the work.

We used those guiding principles to think about what we needed to accomplish over the next three years. It was difficult to look further out than that given the realities of legislative and election cycles. Yet, we knew we needed to bridge forward at least to the next administration.

Our first attempts at articulating a vision were abstract and disconnected from our everyday work.

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Support and development became as important as control and measurement in creating a climate of accountability.

To determine what we specifically wanted to accomplish, we asked ourselves this question, "What do we want to be known for in the eyes of our clients and the community three years from now? What will we have accomplished?" We each contributed our top three to five statements in the form of outcomes, like:

- We will be an agency that loses staff due to their success, not due to their failure.
- We will be an agency that has almost 90 percent of our adoptable children placed within three months of becoming eligible.
- We will be an agency that is respected by the community and that private caregivers want to work with.

Then we tested those statements against our guiding principles and put together a draft set of priorities for our work this year. (See Tool B: Approach to Ranking Priorities.)

We were ready at this point to go out and repeat these steps with our teams of managers, supervisors, and case workers. We designed the method for creating the vision and set the parameters that outlined what was in or out of bounds. Within those parameters we opened up the discussion broadly to create a vision and a set of priorities we could all believe in and aspire to.

What We Learned

Our vision and priority-setting work moved from being abstract to being quite practical. I had been worried at the beginning that we would spend a lot of time talking around issues, wishing the difficult work away, ending up with an exercise in analysis paralysis. Setting deadlines and taking the time up front for people to simply voice their opinions paid off in the long run. Everyone knew there was an endpoint to the discussion, and that their voice would be heard. We posted a schedule of meetings that outlined how everyone would be included.

Being clear up front that the leadership team would be making the final decisions helped as well. It forced me to relinquish some control and put the burden of responsibility squarely on the shoulders of my managers. At first, they were surprised that there were so many things for which I did not need to be the final authority. However, if they were the final authority, they had to tell their supervisors, "I want us to improve our relationship with the judge," instead of "The director said we should ..."

This brought managers together. They needed to support each other when a supervisor tested their resolve by going to more than one manager to question a decision. In addition, my leadership team needed to truly believe in the work they were doing if they were to get their direct reports to own it as well.

Success did not happen overnight. We made a number of false starts along the way. We were sluggish at the beginning, and supervisors and case workers did not believe they were really going to have a voice in the process. We needed the time, however, to come together as a team and agree on what was open for negotiation and what was not. Otherwise we would send mixed messages and derail the very process of ownership throughout the agency that we were trying to put in place.

Along the way we learned that the hierarchy was not such a bad thing after all as long as we each took up our responsibility. In fact we found that it was at least as difficult to find ways to encourage, develop and support the people we work with as it was to tell them what to do. Support and development became as important as control and measurement in creating a climate of accountability.

We learned that if we focused on roles rather than on individual personalities, there

would be less internal fighting. We worked in groups, but pushed back against the wish to come up with group consensus too quickly. We did this in a very simple way, by asking each person to contribute his or her thoughts about an issue from their role point of view before we discussed the issue as a group. Looking at critical issues in terms of roles, we were able to examine how work flowed through the system. We began to reduce duplication of effort and achieve greater consistency and quality in our work.

We realized early on that we were not going to get everyone on board. Some people were going to move, others retire, and still others hang on until the last possible minute. What we needed was critical mass. To accomplish that we had to create enough safety to challenge the pervasive attitude that critique would inevitably lead to someone's retaliating against you. People were skeptical and rightly so. We continue even now to chip away at a long history of internal struggle and external blame in order to address this problem. People have begun to feel encouraged in part because we have some success stories to tell.

We are able to tell many of those success stories because we now have the data to back them up. It seemed ironic to me at first that it took a qualitative process to reinforce the value of quantitative measurement. We worked back from our vision of the agency, and how we wanted to work together, to a set of outcomes that would be our signs of success. When we set targets that could mark milestones and measure that success, the need for data to simply count and manage week to week and year to year suddenly made sense to people, where before it had not. Perhaps this awareness was due partly to the creation of a safe enough environment within which managers could feel comfortable saying they did not know how to gather or manage using data. Management skills became something to develop rather than something one was supposed to be born with.

For further discussion of Case Study One see the following:

- ❑ Tool A: Guiding Principles
- ❑ Tool B: Approach to Ranking Priorities

Case Study One – Tool A: Guiding Principles

Why

Meeting participants often have ideas about what a solution should look like without knowing what the particular solution should be. Sharing those ideas in the form of guiding principles early in the process enables the group to share preferences and capture its thinking as a group. When the initiative is complicated, guiding principles help each group carry out its tasks in straightforward ways.

What

Guiding principles are working agreements about what counts as a good process or solution. Sometimes a principle will describe the criteria for a good recommendation. We will test every recommendation against the questions: "What is best for our clients? and What is best for the agency?" Sometimes a principle will describe how the work will be done – "We will involve frontline workers in the development of programs."

Both types of principles help the group develop recommendations and communications that will support an effective hand off of their work. Note that neither guiding principle is a recommendation or a solution – in the first case, the focus and level of investment is yet to be determined. In the second case, the programs themselves are not designed. However, the principles limit what counts as a desired solution and thereby help focus the work of the group.

Guiding principles are working agreements about what counts as a good process or solution.

Guiding principles can be used whenever a group comes together to address a particular problem or make a recommendation

Because guiding principles are working agreements, the group can choose to change or eliminate a principle if it seems to stand in the way of a good solution. For example, "We will hire from our supervisor work force for the manager positions" might be a guiding principle. It gives everyone an idea of the set of skills and experiences the group prefers in that position. If there were not enough candidates for that role, the group might use the guiding principle to define what the manager position needed, without limiting its view of where those skills might be found.

Guiding principles differ from ground rules in their focus: guiding principles focus on the task and the work both inside and outside of the meeting, while ground rules describe how the members of the group work with each other.

When

A first set of guiding principles is usually developed early in a meeting or initiative. The group often posts the principles for reference during their time together and adds to them as new characteristics or criteria are developed. When workteams or subcommittees are formed, the guiding principles are provided to the new groups to help them understand their task and the perspectives of the task force or steering committee.

Where

Guiding principles can be used whenever a group comes together to address a particular problem or make a recommendation. They are most useful in complicated initiatives that may have a steering committee or a number of workteams addressing different aspects of the task or problem.

How

The group can develop a series of guiding principles, using other brainstorming techniques.

1. The facilitator begins by explaining what guiding principles are, and how they can be useful. He or she might say, "A guiding principle describes what counts as a good solution. An example of a guiding principle is, "All new programs will be pilot tested before finalizing."
2. The facilitator asks members to offer guiding principles.
3. If there is widespread agreement across the group, the principle becomes part of the working agreements of the group. If there is disagreement – or if two candidates for guiding principles conflict – the group can discuss the issue or table both suggestions. It is often useful to note the disagreement, but not rush to resolve it.
4. The list of guiding principles accepted by the group is posted during the meeting. As discussion continues, additional guiding principles may emerge. These can be added to the list.
5. If workteams or subcommittees are formed, the guiding principles should be provided to those groups as part of their orientation to the work. It is useful to post these principles whenever the group comes together to work.

Case Study One – Tool B: Approach to Ranking Priorities

Why

Often groups that are working on complex problems find themselves unable to choose what goals they most need to focus on. They have difficulty identifying which initiatives are most vital to overall success and centering their time and energy on these issues.

This tool is used to:

- ❑ Help a group create a ranking of initiatives from a list of strategic initiatives or operational tasks.
- ❑ Provide a framework for helping groups use both quantitative and qualitative reasoning to create this list.
- ❑ Facilitate consensus building among individuals in the group about which initiatives are important, in what order, and why.

What

This tool is designed to help groups or individuals rank strategic and operational initiatives so that they can develop a realistic and manageable implementation plan. It is based on a simple technique for scoring an initiative by assessing its value with respect to criteria such as "urgency," "importance," and "resource intensity." The intent is to bring individual assumptions or biases regarding the initiatives into the open so that the group can then reach an agreement as to its priorities in a mindful, deliberative way.

Who

Ranking priorities can be done by any group or individual with a complex set of tasks to accomplish and limited time and resources. It is particularly appropriate for groups with unclear authorization or direction either from themselves or from superiors or for groups at the top of their organizations seeking to put a particular vision into action.

How

There are seven steps in ranking priorities.

1. Create the list of possible initiatives.
2. Establish criteria for setting priorities.
3. Rank the criteria.
4. Come to consensus on the criteria.
5. Score the initiatives.
6. Rank the initiatives.
7. Analyze the results of the scores and rankings.

Please take the time to read the next few pages as we walk you through each step using an example. It may look difficult at first, but it's pretty straightforward and will save you a great deal of time in the end.

The list of possible initiatives is created out of a normal process of group deliberation.

Step One:
Creating the List of Possible Initiatives

The list of possible initiatives is created out of a normal process of group deliberation. The goal here is not to eliminate initiatives, but rather to build a comprehensive list that covers the major concerns of the group. A typical group may create a list of 12-15 possible initiatives, knowing that not all members of the group may think that certain items warrant attention and that the resources of the group will never be sufficient to address all the items fully.

A short list of initiatives may include such areas as:

1. Decrease time between intake and investigation.
2. Increase the retention rate of foster parents.
3. Reduce the number of foster families that the typical child stays with while in system.
4. Develop an improved training and mentoring program for social workers.
5. Reorganize the organization structure to be more community based and oriented.
6. Develop a broadly integrated system to coordinate providing mutually reinforcing services to children and biological parents.

Step Two:
Establishing Criteria for Setting Priorities

In order to rank the initiatives, the group must agree on common criteria for judging the options. These can be chosen out of the specific nature of the group's work or developed by the leader for the particular situation at hand. We recommend the following general criteria that can be applied to any set of initiatives.

1. *Urgency* – How urgent is the initiative to the accomplishment of our overall goal or mission? If unaddressed in the short term, does this issue jeopardize operations and prevent us from addressing much of significance?
2. *Precondition* – Is accomplishing this initiative some necessary precondition to the success of another initiative? Do we need to consider where this initiative fits into a sequence of projects?
3. *Importance* – How important is this initiative to the accomplishment of our goal? If we do not undertake it, are we in danger of seriously compromising our efforts? Possible long-term unknown consequences should be considered here equally with shorter-term known consequences.
4. *Resource Intensity* – How resource intensive is this initiative in the time frame at hand? Can we achieve it with currently available resources, or will we need to reduce the allocation to some other project, and what are the consequences if that happens?
5. *Side Effects* – Would accomplishing this initiative risk leading to many negative side effects? These can be interpersonal conflicts, reduced retention rates, alienating stakeholders, etc.

Step Three:
Ranking the Criteria

Before assessing the initiatives, it is necessary to rank the criteria that will be used. The most effective way to do this is to think about the broader problem or challenge that gave rise to the initiatives in the first place. Relative to this broader challenge, is "urgency" of the highest significance, or is it the kind of problem with a high danger of negative "side effects"?

Each member of the group then ranks the criteria by distributing ten points among them. Here are the weighting decisions of two members of a group. Note the differences and move to Step 4. You are more than halfway there.

Criterion	Member A Weight Points
Urgency	1
Importance to the Organization's Strategic Goals	2
Precondition to Other Activities in the Plan	2
Resources Intensity	3
Side Effects	2
Total	10

Criterion	Member B Weight Points
Urgency	3
Importance to the Organization's Strategic Goals	1
Precondition to Other Activities in the Plan	1
Resources Intensity	2
Side Effects	3
Total	10

Step Four:
Coming to Consensus on the Criteria

After each member has ranked the criteria, the rankings across the group of initiatives can be compared and an average score can be calculated for each criterion. To calculate the average for a criterion, add together the weight that each group member gave that criterion and then divide by the number of group members.

Group members can survey the chart looking for places where a person's score differs significantly from the rest of the group. The differences can then be discussed and the process repeated until consensus is reached or the leader of the group makes a final ranking decision.

Below is a chart averaging the weighting of Member A and Member B.

Criterion	Member A Weight Points	Member B Weight Points	Group
Urgency	1	3	(1+3) ÷ 2 = 2
Importance to the Organization's Strategic Goals	2	1	(2+1) ÷ 2 = 1.5
Precondition to Other Activities in the Plan	2	1	(2+1) ÷ 2 = 1.5
Resources Intensity	3	2	(3+2) ÷ 2 = 2.5
Side Effects	2	3	(2+3) ÷ 2 = 2.5
Total	10	10	(10+10) ÷ 2 = 10

So, the final chart showing the group's decision about how much weight each criterion has would look like this:

Criterion	Group Weighting Points
Urgency	2
Importance to the Organization's Strategic Goals	1.5
Precondition to Other Activities in the Plan	1.5
Resources Intensity	2.5
Side Effects	2.5
Total	10

Step Five: Scoring the Initiatives

Each group member will then score *each* initiative on *each* of the criteria. The scale is from zero to ten. A score of zero means that the consequences of passing over this initiative are minor with respect to this criterion. So, a "precondition" score of zero means that this initiative is not vital to the accomplishment of other work.

Conversely, a score of ten means that the consequences of not acting on this initiative are serious. An "urgency" score of ten would mean that the overall success of the organization's goals hinges on the quick accomplishment of this item.

Let's choose several of the initiatives from the list above to focus on:

1. Increase the retention rate of foster parents.
2. Develop an improved training and mentoring program for social workers.
3. Reorganize the organization structure to be more community based and oriented.

Below is the sample Initiative Weight Points chart for one member

Member A:

Criterion	Retention Rate Increase	Improved Training Program	Become Community Based
Urgency	8	1	3
Importance to the Organization's Strategic Goals	8	2	1
Precondition to Other Activities in the Plan	1	3	4
Resources Intensity	1	5	5
Side Effects	1	7	3

Of course, Member B might put together a very different chart.

Member B:

Criterion	Retention Rate Increase	Improved Training Program	Become Community Based
Urgency	2	3	3
Importance to the Organization's Strategic Goals	2	1	1
Precondition to Other Activities in the Plan	3	4	4
Resources Intensity	4	6	7
Side Effects	3	3	1

Step Six: Ranking the Initiatives

The final value of each initiative for each group member is a function of two factors: how the initiative was ranked on each of the criteria and how the group ranked the criteria with respect to each other. For each initiative, multiply its criteria score by each of the corresponding criteria weight points and total the results. Each initiative will then have a single value for each individual reflecting his or her opinion of its priority level and can be ranked relative to all the other priorities.

So, the calculation for the priority weight that Member A assigns to increasing the retention rate of foster parents would look like this:

Criterion	Consensus Criteria (Step 4)	Member A Retention Rate (Step 5)	Criteria Weight Points* Initiative Weight Points
Urgency	2	8	2 • 8 = 16
Importance to the Organization's Strategic Goals	1.5	8	1.5 • 8 = 12
Precondition to Other Activities in the Plan	1.5	1	1.5 • 1 = 1.5
Resources Intensity	2.5	1	2.5 • 1 = 2.5
Side Effects	2.5	1	2.5 • 1 = 2.5
		Total	16 + 12 + 1.5 + 2.5 + 2.5= 34.5

So, Member A gives "Foster Parent Retention Rate Increase" an overall weighting of 34.5. We can create a chart that shows how each member of the group weights the initiatives relative to each other.

Initiatives (Member A)	Member A Weighting
Retention Rate Increase	34.5
Improved Training Program	21
Become Community Based	40

Again, Member B will have a different set (as will Member C and D and ...). For example, it could look like:

Initiatives (Member B)	Member B Weighting
Retention Rate Increase	45
Improved Training Program	33
Become Community Based	27

Step Seven: Analyze the Results of the Scores and Rankings

This last step is similar to the step of ranking the criteria. We can calculate the average score for each initiative across the group by adding together the score from the last step for each member and dividing by the total number of members of the group. This way we can see which initiatives the group as a whole rates as higher priority than others. It can also be useful to calculate what is called the "spread" for each initiative. To do this for an initiative, just subtract the lowest value in the group in this initiative calculated in the last step from the highest.

A result might look something like this chart.

Criterion	Average Score	High Score	Low Score	Spread (High - Low)
Retention Rate Increase	30	45	12	33
Improved Training Program	21	22	18	4
Become Community Based	25	40	16	24

We generally use the following chart to address which initiatives can be postponed, which should be authorized immediately and for which ones disagreement should be resolved now or later.

SPREAD	AVERAGE: LOW	AVERAGE: HIGH
LOW	We all agree on the priority of this initiative. Priority is low. ***Postpone or Abandon.***	We all agree on the priority of this initiative. Priority is high. ***Go Ahead.***
HIGH	While on average we ranked this initiative as unimportant, there is considerable disagreement about this ranking. This difference is likely to provoke interest and curiosity. The differences we feel may highlight some subtle but important differences in how we understand our goal. ***Resolve Later.***	While on average we ranked this initiative as important, there is considerable disagreement about this ranking. This difference is likely to provoke strong feelings. If we fail to resolve this difference our overall effectiveness might be compromised. ***Resolve Now.***

Increasing the retention rate of foster parents, for example, with a high average and high spread should be discussed and resolved now. There are strong feelings in the group that this is an important area to address, but there also may be significant dissension regarding how important it is relative to other initiatives.

CASE STUDY TWO– BUILDING EFFECTIVE WORKING RELATIONSHIPS

Task

One of my responsibilities in my role as a program manager is the development of our supervisors and staff. The director of our agency asked me to develop a climate throughout the agency within which we could build ownership for implementing our collective vision and the priorities we had agreed upon that would make the vision come alive.

We outlined a vision of what we would count as success three years from now, tested that vision with our staff, and made revisions based on their input. We identified a set of critical tasks and prioritized them. Our next job was to take those priorities and decide who would be responsible for moving forward on which ones. It was important that we be clear, consistent, and focused in dividing up responsibility and authority for getting the work accomplished. We knew from past experience that if everyone was responsible for everything, nothing would get done.

I knew accountability had to begin with us, the leaders and managers of the organization. We needed to lay the groundwork for strengthening working relationships throughout the agency – within and across functions from program managers to case workers – in order to move from talk to action. If we were not ready to take on tough discussions about responsibility, authority, commitment and follow-through, we could not reasonably ask those who report to us to do so.

Setting

When we began this process there was little ownership of the work by the agency as a whole, although we had many individuals dedicated to their particular jobs. Whenever there was a problem to solve, however, it would appear on my desk, or end up on the director's desk without my knowledge – until she called me into her office. No one wanted to be blamed for a mistake, but at the same time there was a great deal of fingerpointing whenever something did go wrong. People were frightened when something went wrong and looked for someone else to blame.

Most of our staff had been with us for quite a while and had known each other for a long time. Some had been peers in the past and now reported to each other. Others who had reported to someone now had that person reporting to them. Personal histories often stood in the way of getting work done, and some folks remained bitter over events that happened years ago.

There was a general feeling of rudderlessness. Many believed that, "You could never understand my job, the stress I'm under and how difficult it is." It was as if everyone worked harder than they needed to because they felt a need to protect their own point of view; as if no one else could properly represent them or their views. Consequently, every unit had to be represented at every meeting because they could not trust others to represent their thinking or protect their turf. There was little or no breathing room, and people carried the weight of the world on their shoulders. That weight needed to be distributed differently.

New people entering the system would hang on for a short time, then burn out and leave. Those with longer tenure were exhausted. Accidents began to occur more

frequently. The problem was not as much about the quality of our workers as it was about the culture of work. We were not likely to be able to put our vision into action unless we addressed these dilemmas.

Responsibility Charting helps bring each of our assumptions about our responsibility to the surface and clarify them.

What We Did

I decided to look around for tools we could use to change the ways we made decisions and followed through on them. I wanted people to step up and take responsibility, but knew that we had created a climate in which it was unlikely to happen by itself. Many of the tools available focused on distributing work, but did not address the relationship between responsibility and authority that I believed was at the heart of our dilemma. People often felt they had plenty of responsibility, but little authority. At the same time, they were very ambivalent about taking on authority for fear of being blamed if something went wrong.

I found two tools that helped us distribute the work while negotiating the authority and responsibility people had to get it done: Responsibility Charting and Role Negotiation.

Responsibility Charting

Responsibility Charting helps a group negotiate the kinds of responsibility and authority each of its members has relative to making a decision, creating a plan, or taking action on any issue. Responsibility Charting helps bring each of our assumptions about our responsibility to the surface and clarify them in our own eyes and the eyes of others. This tool helped us build a common language for distributing responsibility and authority clearly within and across levels of the agency.

There are four different kinds of responsibility outlined in the tool that we found useful. If you are responsible for the quality of the final product or result, you have the approval "A." If you have responsibility for getting the work done, you have the "R." Many people in the past thought that if they had the R, they had to do all of the work.

We determined that having the R means you are responsible for seeing that the work gets done, not for actually doing all of it. That was a great relief for some, but initially was a burden for others who were concerned they might lose some control.

One of our managers was put in charge of reorganizing our system for training new social workers. This person was very excited to do the job, but it also put a lot of weight on her shoulders for getting it done. She ended up not making use of the knowledge of the people around her as well as she could. She was trying to design and pilot the new system even while soliciting input from her peers and staff. It ended up taking much more time than it should and not being as effective as it could have been. When we went back to redesign the system again, we made sure that she let someone else help her with pulling together everyone's recommendations and organizing it. She discovered that the work ended up being easier and also better as she had more time to devote to the key parts that she worked on best.

There are many people within and outside the agency who have relevant knowledge and experience that can add to the quality of a decision, plan, or course of action. These people act as consultants in a "C" role. At first we thought that it was the job of the person with the R to find and choose the Cs. Later we decided that others can ask for a C. Initially, people went one of three ways: they were either too shy to request a C, they wanted to have a C on everything, or they suggested everyone have a C on everything.

That changed as people realized that the last type of responsibility, "I," referred to those who would be informed by the person with the R. They had to be informed, and it was part of the R's job to make sure it happened. This allowed people the freedom to decide when they wanted to step up and take a C role or simply remain an I.

It was the management team's task to use this tool to distribute the responsibility

for moving the work of our priorities forward. We also had to teach the tool to staff who reported to us. We had numerous small and large group meetings with multiple layers of the organization in the room over a few months. To make the tool our own, we used real examples of everyday work decisions and modified the Responsibility Charting language until it fit our situation.

The beauty of this approach is that each person has to privately fill out the responsibilities (A, R, C, I) for themselves and others as they see them before discussion begins. We rapidly discovered the differences in our points of view about the same task. We could literally tabulate how many people thought a particular person/role (e.g., foster care supervisor) should have the A or R for a specific task. With this information we could work toward a consensus that made differences of opinion a valued part of the negotiation.

In the management team, we charted each person's expectations about who would be responsible for what parts of each priority. By looking at ten or twelve issues at a time, we could see who needed to be involved and in what capacity. We saw immediately, for example, that certain roles and units were assigned too much or too little responsibility. In some cases, we negotiated with people to take on more or less responsibility. These negotiations, however, were always based on the task to be accomplished and the responsibility involved, *not* on the personalities of the individual in that role.

What We Learned

We learned that if you have the responsibility for a piece of work, and you are doing it all yourself, you are probably working too hard and not effectively using the knowledge available in the system. As a group we were able to take on many more tasks when we could divide up the responsibility and begin to use each other's knowledge and expertise more often.

We learned that everyone did not need to attend every meeting if we believed our point of view could be represented fairly in our absence. One way to accomplish this was to take a consulting role. This meant we had to negotiate with the person who had the R about how much our consultation would count. One case where this proved to be important was in deciding just how much information about the kids in our system and their families we should track. Ideally, we would want to know as much as possible, but there is a limit to how much we can take in and still have enough control over it for it to be useful. So, we had to pick and choose as well as figure out a system to make it thorough and valuable to the people who would use it. This required a great deal of consultation from various staff members, but ultimately one small group was responsible for deciding the recommendation to take to the commissioner.

We were able to identify and discuss our assumptions about leadership, power, authority, and responsibility in a structured and nonthreatening way. We had never articulated those assumptions to each other – or in some cases to ourselves – much less felt it was okay to challenge each other or negotiate for an agreement we could live with. Responsibility Charting provided a safe way to discuss these issues, and it linked the discussion to concrete tasks that we needed to accomplish.

People learned that the director and the program managers did not want to have the A on everything. I was surprised, for example, that other people thought I wanted more authority than I actually did. I had to actually say that I did not want – that I did not want sole, final approval on what our group's recommendation to the commissioner for data tracking would be – before people believed me. That taught me something about how I was perceived by others. We all began to understand that leadership can be successfully distributed, and that sometimes it is better

We saw immediately that certain roles and units were assigned too much or too little responsibility.

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to have the A close to the delivery of services to our clients while at other times it is not.

Finally, we learned that this work takes time and commitment. It took us a few months to get comfortable with a new way of making decisions, but then we began to pick up speed.

Role Negotiation

Another tool that helped us get our priorities off the ground was Role Negotiation. Role Negotiation outlines a way to give and receive concrete feedback. It can be used vertically (between people who report to each other) or across functions among peers who have different kinds of responsibility.

We needed a new climate within which people would feel safe enough to take the risk to both give and receive feedback. There are many different ways to do this, but we found one that works well for us. I like a version that structures the conversation in a way that creates a feeling of safety, since we had a history of blame and fear of retribution after speaking up.

To accomplish this, we made sure that the negotiation focused on people talking with each other about how to be more effective in their role and in accomplishing the tasks they were responsible for. We wanted to get away from the kind of interpersonal history that focused more on blame than encouragement. The bottom line was that we needed to increase productivity at a time of decreased resources. We needed a feedback tool that built on peoples' strengths, as well as their challenges. Finally, we wanted the conversations to occur at regular intervals over time, and to incorporate a method of setting expectations, making agreements, celebrating successes, and moving forward.

We needed a feedback tool that built on peoples' strengths, as well as their challenges.

Our assumption was that trust is really about agreeing on setting and testing expectations of each other. We gambled that using role negotiation to establish trust would help us build stronger working relationships and increase productivity. We did not need another workshop on team building; we needed to practice it in our everyday working lives with the people we work with regularly.

Role Negotiation works quite simply. It calls for each person in the negotiation pair to prepare in advance a couple of examples that answer each of the following questions – what could the other person do more of, less of, and the same in order to help me be more effective in my role?

During the negotiation, each has the opportunity to bring those examples forward, including feedback that is concrete, timely, and does not attribute motives to the other's behavior. At the end of the discussion, each of the participants agrees on at least one thing they will follow through on from each of the three categories (more of, less of, and the same). The emphasis on roles rather than personalities makes this experience very different than having an interpersonal discussion.

What We Learned

This takes time to do well. We began working with the management team and discovered quickly that this is a very different way of working from what we had been used to. We gradually moved from a culture where we either told people what to do, or they asked us to tell them, to one in which roles and tasks were negotiable. It took time to build trust, create a shared language, and put the tools to use in everyday work settings to get real work done.

The hierarchy did not go away, nor did the need for leadership. The director and her leadership team still provide the parameters within which the entire agency operates. She and the leadership team are ultimately responsible for the organization. It is part of their responsibility to provide the support, resources, and development opportunities we need to do our work. In turn they hold us accountable for the quality and the results of that work.

This is all relatively easy to describe, but at times very difficult to do. Sometimes I have to give up power, and other times I have to reclaim it and take the A or the R role. This demands a different kind of honesty and rigor from my staff, my boss, and myself. It is not easy, but we are getting a lot more accomplished than we were before, and the quality of our work is improving.

We learned that the fear of retaliation runs deep and strong. It is easier to remember things that go wrong than it is to remember things that go right. We learned that we all need to get help from each other. In the past it used to be the same few people who were overworked. Now the work and responsibility are distributed more evenly as appropriate to each task. I learned that I did not need to figure it all out by myself, and that I can get help from my staff.

I have become more concrete when I set expectations because once they are created, I have to manage them. I now make my thinking more publicly available to others even when it is not yet completely worked through. It is easier to do that now because whatever I say is no longer taken as a commandment.

Not everybody wanted to buy into the changes we initiated, and that was disappointing at first. The fact is, when we are making changes, we are not likely to get everyone on board. We just need enough people to create momentum.

This does not mean that I now live in paradise, but I do have more time to focus outside to the community as well as inside the agency. Instead of being so caught up in our own complexity that we sometimes lose track of why we were here, we are now focused less on ourselves and more on our goal of improving the lives of kids and families.

For further discussion about Case Study Two refer to the following:

- ❑ Responsibility Charting
- ❑ Role Negotiation

Case Study Two – Tool A: Responsibility Charting

Why

Responsibility Charting is used to:

- ❑ Clarify group or individual responsibilities for specific tasks or decisions
- ❑ Resolve differences in understanding those responsibilities
- ❑ Support accountability for and effective delegation of tasks

The tool is especially helpful in describing and assigning responsibilities for complex tasks and decisions that cut across units or formal roles and pose a challenge to newly formed teams and task forces.

What

Participants can use Responsibility Charting to clarify the often complex relationships among tasks or decisions, roles, and types of responsibility between themselves. In relationship to a particular task, for example, someone may:

- ❑ Have the authority to approve (A) an action,
- ❑ Be responsible (R) for assembling alternative actions,
- ❑ Be accountable for offering consultation (C) on alternatives, or
- ❑ Need to be informed (I) once an action has been taken.

When discussing each of these types of responsibilities, the codes, A (authority), R (responsibility), C (consult) and I (inform), are very useful. Also note that a given individual may have multiple responsibilities. (See *Example: Responsibility Charting.*)

Where

Responsibility Charting can be used with leadership management teams, special workgroups, and task forces. When the meeting is large, it is helpful to do the analysis outside of the meeting.

I learned that I did not need to figure it all out by myself, and that I can get help from my staff.

When

Responsibility Charting can be used at any stage of a meeting or initiative cycle when tasks have been defined and responsibilities need to be clarified. The process can be quite lengthy, and enough time should be allotted for a full discussion of roles.

How to Use Responsibility Charting

1. Make a chart, or use a prepared form. (See Responsibility Chart Grid.)

Down the left side list the decisions that are at issue. Depending on the group's charge, they may be decisions that are made during everyday operations or proposed decisions for a new project or initiative. Across the top list the relevant actors regardless of whether they are inside or outside of the organization.

2. Decide upon or propose codes to describe types of participation. The most common terms are:

A = *approve* – a person who must sign off or veto a decision before it is implemented or selected from options developed by the R person. The A person is accountable for the quality of the decision or task.

R = *responsible* – the person who takes the initiative in the particular area, develops the alternatives, analyzes the situation, makes the initial recommendation, and is accountable if nothing happens.

C = *consulted* – a person who must be consulted prior to a decision being reached but with no veto power.

I = *informed* – a person who must be notified after a decision, but before it is publicly announced; someone who needs to know the outcome for other related tasks, but need not give input.

DK = *don't know.*

A blank indicates no relationship.

3. Guide the group in filling out the chart.

Give each participant a copy of the chart and the definitions of the types of responsibilities.

4. Record and report the responses.

Record the aggregate results on a larger version of the same chart so that it can be seen by the whole group. Alternatively, you may use a smaller form and distribute copies to the group. Ideally, this should be done after the first meeting, with a later meeting scheduled for analysis and discussion. It helps to record the results to aid in the negotiations that follow once participants learn that there are differences among themselves.

5. Analyze and discuss the responses.

There are three major aspects to the analysis:

- ❑ Discussion of differences in how people or groups understand how decisions are being made
- ❑ Analysis of patterns across the roles (horizontal)
- ❑ Analysis of patterns down the decisions or tasks (vertical)

Consult *Responsibility Charting: Making Sense of the Charts* for guidance.

Example: Responsibility Charting

Responsibility Charting:
Making Sense of the Charts

Discussion of Differences in How People or Groups Understand the Decisionmaking Process

If a large number of discrepancies exist between the codes entered by the decision-maker for him or herself and those entered by others, the group needs to clarify what is going on. Often the process of responsibility charting itself will help to improve this condition.

A = Approve R = Responsible
C = Consult I = Inform

You See Your Role As	Others See It As	Consequences
A	R	You are waiting to make a final decision and looking to others to develop alternatives. They are looking to you for major initiative. Possible lack of action in this area, with you blaming others for not delivering when they in turn are looking to you.
R	A	You want the central role, one in which you develop alternatives, while others see you as a final sign off and perhaps give you too little information and involve you late in the decision process.
C	I	You want a chance to make a substantive input before the decision. Others see you as only needing to be informed.
I	C	You want to know the decision but not be involved. Others will draw on your time expecting input when you do not feel the need for involvement. Problems arise when others wait for your response, when you feel you are being informed.

Once people have a shared understanding of the allocation of responsibility, they can turn to the overall patterns.

Analysis of Patterns Across the Roles (Vertical)

Case Study Two – Tool B: Role Negotiation

Findings	Possible Interpretation or Questions
1. Many R's	Can or need the individual stay on top of so much?
2. No empty spaces	Does the person need to be involved in so many decisions? Could C's be reduced to I's? Could involvement be at the discretion of others?
3. No R's or A's	If a line position, it may be a weak role that could either be enlarged or eliminated.
4. Pattern and personality	Does the pattern and style of the role fit the personality of the occupant – either too little involvement, too much, etc.?

Findings	Possible Interpretation or Questions
1. No R's	Job may not get done; everyone is waiting to approve, be consulted or informed; no one sees it as his or her role to take the initiative.
2. Many A's	Diminished accountability. With so many people signing off, it may be too easy to shift the blame around.
3. Many C's	Do all those individuals really need to be consulted? Have the costs of consulting in terms of delay and communication time been weighed against the benefits of more input?
4. Many I's	Do all those individuals need to be routinely informed, or could they be informed only in exceptional circumstances?

Role Negotiation

Why

This tool helps clarify expectations. It enables participants to get past formal job descriptions and discuss the informal understandings, agreements, and arrangements that often have more influence on how people take up their workplace responsibilities.

What

Role negotiation assumes that most people prefer a fair, negotiated understanding about roles to a state of unresolved conflict, and that they are willing to invest time and make modest concessions to one another. For this tool to be effective, participants must be open about the changes in behavior, authority, or responsibility they wish to obtain from others and that they themselves are willing to make.

Where

Role negotiation is best used in small meetings. Teams in which members share the same level of authority, or in which members know each other well, can readily use this tool. No matter how structured the exchange might be, it may be difficult for a boss and a subordinate to have an open conversation about roles and expectations.

When

Role negotiation can be used at any stage of an *initiative*. It can be used at the beginning of an initiative in which participants have a history of working together and need to learn new behaviors with respect to each other. Alternatively, it may be used at the middle or end of an initiative, whenever participants' behavior has become an issue or they need to clarify how they should work together on new tasks.

How to Use Role Negotiation

1. Each participant takes a few moments to list behaviors they want more of, less of, or the same amount of from each of the others. The descriptions should be clear, specific, and focused on observable actions rather than character traits.
2. Each participant receives the lists about his or her behaviors and makes a summary of the items.
3. Participants share their summary lists by 4. reading them or posting them on flipcharts.
4. Each participant takes a few moments to ask clarifying questions about the items, and then asks the other participants which ones are most in need of change.
5. Each participant discusses how he or she might make changes in behavior and what would be hard about making changes.
6. The group agrees on a timetable for making changes.

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Example: Role Negotiation

Mary Wants from Fred	Fred Wants from Mary
• keep up leaner, less verbose memos	• 1 1/2 hours/wk is good for supervision
+ early warning when potential trouble, negative information	+ clarity and consistency in direction and input program
+ opportunities to collaborate	+ believing I want and value her collaboration
+ willingness to think, redesign, reconsider the program's aim and approach	+ clarity about parameters of my role
+ empathic support for the line workers, representation of their interests	+ real supportive yet not less tough
+ direct expression of his feelings – e.g., anger, let it out, get mad	+ front end discussions, less on implementation
– telling me he's delegated it to Joe	+ more warning when she's going to get involved
– buffering from Joe	– detailed focused or shifting levels of concerns
– distortion of my messages as delegated down the line	– each deskilling each other
– less taking my suggestions as commands	– ambiguous directions
– beating on-line workers for numbers	

• = keep the same

+ = more

– = less

Goals for Effective Feedback

1. Feedback that the other can hear without distorting or becoming defensive.
2. Feedback that the other can test.
3. Feedback that the other can do something about if he/she chooses.

CASE STUDY THREE– GETTING TASK FORCES OFF THE GROUND

Task

As the director of our statewide reform initiative, I was responsible for restructuring the design and delivery of the human services system that oversaw services to children and families. My office had been charged by the governor and the heads of a number of departments to implement a system-wide reform initiative based on a set of guiding principles. Within the boundaries of those principles, we were free to do whatever we could get people to agree to do.

In order to accomplish this task, I needed to bring together representatives from a number of departments at the state and local level to create the kind of ownership needed to successfully restructure these delivery systems. I asked representatives from all state agencies affected by changes in the delivery system to take time out of their regular jobs to participate in a task force. The task force's job, as I understood it, was to determine what was possible and make it happen. There was no way that as the director of this effort I could possibly restructure anything without their commitment.

Setting

About two years before we began our work, the governor had convened an inter-departmental executive committee composed of the heads of a number of key departments. Their task was to meet periodically to guide the initiative. They established a set of guiding principles that included:

- ❑ Maximizing family-centered, home- and community-based services.
- ❑ Increasing local authority to plan, implement, and monitor children and family services on an interagency basis.
- ❑ Shifting resources to prevention and early intervention efforts.
- ❑ Ensuring that the interdepartmental budget for children and family services reflects the priorities of the governor's interdepartmental executive committee.
- ❑ Ensuring system-wide oversight, monitoring, and coordination through the governor's executive committee.

The task force was formed after we had been at work designing and piloting reform efforts for quite a while in a number of local sites. Many state and local departments had gone along with our pilot experiments, so we thought it was time to implement desired changes statewide. Ours is a state-driven, rather than county-driven state. We thought this could help speed things up since governance structures were more tightly coupled across counties and linked to the state government. We were in for a few surprises.

What We Did

During its first few meetings, the task force seemed to be getting off the ground quite effectively. Participants were excited, although not everyone could make every meeting, and there were new faces each time. We had stimulating conversations and did not feel

immediately pressed to move from thought to action. Looking back, we now call that our "honeymoon" period.

After we had been working together for about two months, I realized that we could arrive at an abstract and easy consensus on the importance of addressing any number of critical issues. However, when we began to unpack each issue to explore how we could each contribute, we discovered that a number of things stood in our way.

We each recreated our own particular departmental approach to a problem. It became clear that departmental approaches were tied not only to how people were accustomed to working, but to how jobs were described and budgets were created. Challenging assumptions that would lead to changes in approaching service delivery quickly threatened the budgetary turf that had been built over many, many years.

We found that attendance at meetings was inconsistent. If someone could not attend, he or she would send a different representative in their place. Consequently, it felt like we were always starting over again, or we could not come to a decision because the person standing in could not speak on behalf of the person he or she was representing.

It seemed that every time we raised an issue there were other issues behind it that we could not come to agreement on, many of which were unspoken. After a number of months of meeting together, our discussions moved from an attempt to build an implementation plan to blaming each other for not being able to do so. Some people thought the new vision for delivering services was being imposed on them by others in the room. Some thought that others in the group were being deliberately obstinate in order to keep the existing structure in place and protect the status quo. More conversations were taking place in the hallways and fewer in the meeting. People began attributing motives to the behavior of others, including an intentional blindness to the problems at hand. We all agreed that it was extremely difficult to be riding a train while building it, especially when it kept picking up speed. We were frustrated. We were stuck.

In conversations with my colleagues in similar settings around the country, I learned that our problems were far from unique. As I thought about it, we were in the middle of four kinds of confusion.

1. What was our task anyway? Just what was it that we were being asked to do? Each of us came to this work with a lot of assumptions about how it should be done.

As a group, however, we had not negotiated through our differences to a consensus as to just what our task was.

2. What people/roles were needed to work effectively on the task? Not only did we have people sending representatives with varying degrees of independence but it seemed like there were some people missing. Who may have been able to help us move forward that was not currently in the room?

3. What was the scope of our authority? Were we a group organized to offer recommendations to the governor? Were we a group that was supposed to take action based on our own best thinking or was there a mix of these two responsibilities? It occurred to me that perhaps one of the reasons we were confused had to do with what we were authorized to do and how it would affect who each department sent as a representative and how seriously they would take their work.

4. How and to whom were we accountable? It was obvious to me that I was responsible to the governor and that each individual felt responsible to and accountable to the head of their department. To whom were we as a group accountable? To our bosses, to our clients, to our constituencies? We needed to know this in order to be able to connect our task to the results we wanted to achieve.

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We needed to know to whom we were accountable for achieving those results.

After sorting this out, I noticed that all of our difficulties had something to do with the difference between being a set of individuals representing particular departmental positions and being an interdependent workgroup. I scrapped the prior agendas for the next few meetings and raised questions concerning our task, authority, composition, and accountability instead. I revised my immediate goal; we needed to form a workgroup in order to get our work done. It sounded simple. It was not.

What We Learned

Focusing on these four issues raised many questions and helped us begin to work much more effectively together.

When we addressed questions about our task, we learned a number of things, primarily about how difficult it is to move from independent perspectives that represent each department's point of view to an understanding of our task as a group. To accomplish this, we spent some time learning about what each department actually does, including what resources they had been devoting to revamping children and family services.

Our ignorance about what different departments did kept us from moving forward together.

Our ignorance about what different departments did kept us from moving forward together. We learned there was a great deal of duplicated effort that could be eliminated if we no longer worked in isolation. We came face to face with the risk of changing the way resources are distributed within departments as well as across them. We looked history and inertia in the eye.

We began to understand why we had been spinning our wheels and becoming confused; there was a lot more at stake than we first imagined. The good news was we now had a common task as our focus: to improve, together, the lives of kids and families. The bad news was we had come face to face with the challenge of changing some of the ways we worked back home in our departments. Once we faced that fear, we realized that there was much that could be done without dismantling existing budgets and departments. We knew from past experience that restructuring departments could actually divert us from our focus. By addressing the task of system-wide reform and getting past the fear of losing resources if we exposed our intentions, we began to see how much each of us needed the others. There was plenty of room for collaboration within and across existing structures, at least for the time being.

When we addressed the scope of our authority, we found ourselves raising some critical questions that stood in the way of participating fully in the task force. Did we have the right to act on the plans we made? Where did we get our authority? The obvious and easy answer was that our authority came from the governor and the group of department heads that asked us to come together and work on this. However, when we pushed to ask each of ourselves what we felt authorized to do, some felt authorized to plan and not act, some to make decisions and act, and a few of us did not know what the limits of our authorization were.

Some task force members believed they were acting as observers who would report back what they heard. Others were acting as delegates who represented the voice of their leaders – not necessarily their own. Still others believed that they represented their department and could, in the end, make decisions on behalf of that department without checking first.

We decided to use Responsibility Charting to negotiate a consensus about what we thought the scope of our authority ought to be. We did that by taking each part of our task and deciding first independently what each member wanted our authority to be. Then we looked collectively at our individual points of view in order to create a negotiated consensus within the group. We each went back to our respective departments to discuss this with the leaders of our depart-

ments. Following that we met with the governor and his group of department heads. We figured that the discussions we had independently might change when the department heads met with each other and the governor as a group. (They did, but not much. We actually ended up with more authority to act than we thought we would, which placed a greater burden on us.)

When we returned from our conversations about the scope of our authority, we revisited our task and realized a number of questions had emerged about the composition of our group. Were there departments or groups that we needed that were not currently represented? Were we the right people not only to plan and make recommendations, but to make the kind of resource-allocation changes within our respective departments that would be needed to move system reform forward? It was one thing to ask people to add work to their regular jobs but in some cases we would need to shift people from one role to another or ask them to devote chunks of time to new and different tasks. We needed people with enough authority to make those decisions in their home departments.

Until now we had focused on the state level and had not included local planning officials as regular standing members. We decided in the short term that we needed to get our own house in order but would ask local representatives and community members to join the group on a consulting basis for the next six to nine months, and then invite them on as more permanent members. Deliberations about the composition of our group caused us to make recommendations to the governor about making a few changes in the composition of his group.

While we had a better understanding of our task, we had not actually decided what the outcome of our work should be, how we would recognize if we had succeeded or failed, and what the timeframe was for accomplishing our work. We had been asked to work together without a clear sense of the end results of our work and consequently without a clear sense of just whom we were accountable for delivering it to. We needed to create the boundaries within which we could work. Without them we would have continued to flounder. We now knew where we got our authority. However, we believed that to be effective we had to meet the expectations not only of the governor's group but of the departments we represented and the local governance entities we hoped to influence as well. In short, we realized that accountability meant setting and meeting expectations with those we hoped to influence through our work. As we began to do this, we discovered that these three sets of stakeholder groups were more willing to work with us – they knew we were going to be accountable to them. This made our work over time much more clearly defined and our recommendations more likely to be implemented.

For further discussion of Case Study Three see the following:

- ❑ Tool A: Task Forces: Beginning the Work
- ❑ Tool B: Driving an Initiative
- ❑ Tool C: Defining, Clarifying, and Confirming the Task of an Initiative

A task force complements the existing work structure while cutting across hierarchical and organizational boundaries.

Case Study Three – Tool A: Task Forces: Beginning the Work

Why

Task forces are often created as a method of allowing people who need to work together to accomplish some goal to access each other in ways that are outside their usual organizational lives. A task force complements the existing work structure while cutting across hierarchical and organizational boundaries. Frequently, however, these groups are assembled in such a way that their effectiveness is hamstrung from the outset. Such groups have typically been created without adequately addressing four key issues:

Those affected by the change should be included in its design.

- ❑ The authority the group carries.
- ❑ The appropriate composition of the group.
- ❑ Who the group and its members are ultimately accountable to.
- ❑ The precise nature of the task that group is supposed to accomplish.

What

This tool is designed to provide a list of questions that can be used to begin to address four issues which often cause task forces to flounder. This is certainly not an exhaustive list, rather it is a beginning from which to start a discussion around these issues.

How

Early in the work of the group raise the following questions for discussion:

Authority

- ❑ Where does the group get the authority to do the work?
- ❑ Does the group have the authority to do the work as it understands it?
- ❑ How can the group get the support it needs to do the work?
- ❑ Who has authority within the group? How much authority is carried over from roles outside the task force? How much are people's ability to speak their mind limited by their authority (or lack of it) elsewhere?
- ❑ What is the role of their chairperson? Of the facilitator?
- ❑ What authority does the group have for commanding resources outside the task force?

Composition

- ❑ Who needs to be in the group in order to address the problem adequately? A few general rules are helpful:
- ❑ Those affected by the change should be included in its design.
- ❑ Bring important but problematic people into the group at the beginning to avoid serious problems and roadblocks down the line.
- ❑ Who can the group bring in occasionally on a consulting basis to add insight without having them present all the time and adding excess weight?
- ❑ How will you add members if it becomes necessary?
- ❑ Who mediates between pressures each member feels in their regular work versus in their task force work?

Accountability

- ❑ Who is the group accountable to? Different types of accountability can flow both up and down the organization structure. Are members here as representatives and accountable to their home office?
- ❑ What form should reporting take, how often, and to whom?
- ❑ What is the time frame within which the group must accomplish its task? What milestones should be established to make sure that deadline is met? At what point is the group to be dissolved?
- ❑ How will the group record its work in order to create an organizational memory of their efforts?
- ❑ How will members hold each other accountable for doing the work and for taking up their roles in the group?
- ❑ How often will the task force meet? Will everyone have to attend each meeting? What is the procedure for keeping those who may miss a meeting informed?
- ❑ Who is accountable to the task force, e.g., for providing support, for granting it the authority to do its work, for following through on its recommendations?

Task

- ❑ What is the task? During the course of the work, you may discover that the task you

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were officially assigned is not the best one to pursue or that the source of the problem has changed. How do you go about changing task in midstream? Redefining the task may send you back to reexamine the composition of the group and the authority it has to do its work.

- ❑ Can the group avoid stating the problem in terms of a preferred solution, an untested assumption, or a hunch based on inadequate evidence?
- ❑ Can you keep the discussion open and resist coming to closure before gathering all the data you need to address the question at hand?

Case Study Three – Tool B: Driving an Initiative

Why

Sometimes a problem arises that is too complex to be handled within a single department or through the established chain of command. A special project must be formed that includes a team of people from several divisions or departments. This kind of project is called an initiative. Meetings play a key role in defining the issues and the task, keeping the effort on track.

What

An initiative takes on an important problem whose effective solution requires that people work together outside of their typical job responsibilities. The people may be from different parts of the agency or department, or they may be working together in new ways. They participate in the initiative through a series of meetings as well as by carrying out specific tasks.

An initiative is charged by someone whose authority will help the team accomplish its goals. The team builds a meeting system – a series of linked meetings – to support its efforts. When the project is completed, the team hands off its deliverables to the sponsors, who then delegate its eventual implementation. Each of the parts of an initiative presents its own distinctive challenges, that are addressed in other sections.

Examples of initiatives include:

- ❑ Drafting a plan for working effectively with community groups or the media.
- ❑ Designing a community-based foster care system.
- ❑ Rolling out a new product or program.
- ❑ Creating a vision of the workforce of the future.

Who

The leaders of the initiative drive the process. To do so successfully, the executive sponsor or sponsors must authorize and resource the initiative. The members of the initiative team must contain or access the necessary skills. However, it is the initiative or task force leaders who are most closely involved with the work and check in with the sponsors at key points in the process.

When

An initiative is appropriate when the executive sponsors believe that the issue at hand is important and urgent enough to devote resources to developing solutions. If the issue is important, but crowded out by other, more urgent problems, it may be better to delay the initiative rather than begin an effort that will not command attention and resources.

How

Initiatives are more likely to succeed if they contain the elements of good design. These include:

- ❑ Clear goals and an explicit charge from the executive sponsors.
- ❑ Identifiable steps that start with a well-defined problem and work toward its solution at each of the initiative's full-group and workteam meetings.
- ❑ Workteams that concentrate on smaller parts of a larger problem.

Initiatives are more likely to succeed if they contain the elements of good design.

- ❑ Clear objectives and appropriate tools for each meeting of the entire initiative group and the workteams.
- ❑ Prework to guide preparation for each meeting.
- ❑ Follow-up memos to support and monitor progress on action steps to be taken after a meeting.
- ❑ Guidelines for implementation planning.

There are many tools to help you drive an initiative. Most of them build on what managers already do. The chart below provides an overview of these tools.

There are many tools to help you drive an initiative.

Tool	Task
Charging Memo	Authorizing an initiative
Planning an Initiative	Developing a meetings map
Defining the Task	Using meeting systems to clarify and confirm the task
Roles	Defining the roles of the participants in an initiative
Communication	Communicating with sponsors, participants, and stakeholders
Project on a Page	Designing meetings for different objectives as the initiative progresses
Using a Meetings Map	Creating a meetings map
Hand Off	Delivering the initiative's final products to the executive sponsors

Case Study Three – Tool C: Defining, Clarifying, and Confirming the Task of an Initiative

Why

Initiative leaders, participants, and executive sponsors frequently make the wrong assumptions about what the others know and are capable of doing, especially in the early stages of an initiative. The leaders think the sponsors know exactly how to define the problem that the initiative is supposed to be analyzing. The sponsors are expecting the leaders to go off and define the problem, then return with solutions for review. The participants think the sponsors may have already found the solution and have organized the initiative to get people to "buy into" it.

Most likely, the truth is that no one knows precisely how to define the problem, how to begin tackling it, or where the work will end up. More often than not, an initiative must first put a vaguely understood risk – a demographic shift, the arrival of new competitors on the scene, a technological change – into words. If it does this well, it has made significant progress. Then the remaining challenge is to identify solutions and recommend actions.

Task forces, special projects, and other initiatives are paradoxical at their very roots. To do a job, they must first define it. Yet the executive sponsors are looking for results, not words. So initiative leaders often find themselves in a Catch-22 situation: be task-focused about a task that is undefined. How can they even begin? The answer lies in an ongoing give-and-take among all of the key players – executive sponsors, initiative leaders, participants, and stakeholders.

What

A meetings system is built around forums where this give-and-take can happen. The executive sponsors charge the initiative. The participants discuss the charge. The initiative leaders debrief with the sponsors about how the charge was understood. The charge is clarified as some provisional solutions are brainstormed. The sponsors give the nod to some and take others out of the running. To refine alternatives, workgroups create scenarios and mock up pro forma numbers. This process – proposing, reacting, clarifying, and refining – unfolds over several weeks or months and in many different places. Along the way, choices are being made that shape the eventual recommendations. The process is more like an extended conversation than a series of interim reports. Over time, a shared point of view emerges.

Where

The executive sponsors begin defining the task – or problem – in their initial charge. The leaders and participants clarify the task in subsequent meetings, even as they are identifying possible solutions. In briefings throughout the initiative, the sponsors have opportunities to confirm that the work is headed toward the desired kind of outcomes.

When

This is an ongoing, somewhat unpredictable process, and leaders should be flexible enough to respond to opportunities as they arise. However, there is a basic structure to keep in mind. Charging memos and other early communications about the initiative begin to define the task. The launch of work groups is another opportunity to check for understanding. If the executive sponsors step into the background once the initiative is fully underway, they should become more closely involved again when the deliverables from different workgroups are being integrated into recommendations. Once these are drafted, they can be taken to the full initiative group for review and approval.

How

Task force leaders are the ones who must take responsibility for making sure that their initiative has a clear – or clear enough – charge. Here are guidelines for them to follow:

Before an initiative is formally launched ...

- ❑ Make sure that an initiative has a clearly identified sponsor or sponsors.
- ❑ Ask the sponsor to put the charge in writing. If need be, initiative leaders can draft the charge for the sponsor to review and edit.

When the initiative begins ...

- ❑ Make it clear to participants that a charge is meant to be interpreted.

In the early stages of the initiative ...

- ❑ Check in regularly with the sponsors about clarifications to the charge.

When solutions first begin to take shape ...

- ❑ Brief the sponsors about the leading alternatives.
- ❑ Ask for direction in evaluating and refining the solutions.

When the workgroups have produced their deliverables ...

- ❑ Request the sponsors' guidance in pulling together their materials into a set of recommendations.

Check in regularly with the sponsors about clarifications to the charge.

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CASE STUDY FOUR– CREATING A FRAMEWORK FOR MANAGING PROJECTS

Task

As a mid-level manager, my task was to take one of the priorities that our workgroup was responsible for and build a framework for managing the work we had to do to accomplish it. Specifically, we decided to focus on reducing our intake time. It was taking too long from the initial call coming in to the point where we had fully assessed the situation and taken the appropriate steps. This was not a simple matter we realized because it involved a number of different staff members who were not all in the same group or office, and all the information that had to flow well between them if we were to do our job in a timely and effective way. So, we had to figure out what all the pieces were that had to work well together and which ones we could most improve with our resources.

I intended to work with my team to identify those responsible on our staff for each task, using the priorities tool. In addition, we would need to identify those outside our group who needed to be involved in the process. There were a number of groups that had a stake in the success, or demise, of our efforts. I knew from past experience that involving people early in the process would make their full participation and buy-in more likely later on.

Part of my task was to propose a method for the team to map and monitor the work as it played out over time. In effect, the team had a double task: to plan how to get the work done and to implement it.

Setting

We were pleased with ourselves for building a shared vision and establishing a set of priorities; but it still seemed a little abstract. We had been down this kind of a road before. People's hopes and expectations had been raised. What would happen? We had a history of beginning initiatives and then rarely following through on them. Sometimes the rug got pulled out from under us in the middle, and we were told to switch gears and focus on other things. Other times work was only done by a few people, and others resisted or rejected proposed changes. Sometimes we ended up planning to plan and doing nothing else.

I knew we would need to figure out how to sustain interest over time in the work we were doing. In the midst of our planning effort, we had just gone through another restructuring of the agency, and that changed reporting relationships once again. Many people reported feeling like we were rearranging the deck chairs on the Titanic.

On top of that, everyone knew that elections were not far off and that could mean yet another restructuring. Some people were mumbling that familiar mantra, "This too will pass." I needed a way to create an action plan that could be flexible enough to address the problems of reducing intake time that I was responsible for and, at the same time, could help us maneuver through the continuous change that had become part of our daily lives.

What We Did

I decided to get the people involved who would be responsible for executing the work as well as some other people whom I knew to be good thinkers and planners. I wanted both kinds of people involved from the start.

Rather than discuss the content of the work on reducing intake time, what follows are the steps we took to create the framework for managing our work. We have since found that this framework is useful in tackling all sorts of projects.

1. We pulled the team together and began outlining the outcomes we wanted to achieve and when we needed to achieve them. We began with the end in mind. We knew we were not exactly right, but this allowed each of us to put our expectations on the table and test them. We knew roughly what we were working toward.

2. We then used the priorities tool to identify and rank the tasks on the critical path to reaching the outcomes identified in the first step. We used Responsibility Charting to distribute responsibility for accomplishing the tasks.

3. This cleared the way for us to construct a timeline and identify milestones along the way toward our desired outcomes. The milestones helped us to feel less pressured to accomplish the work all at once, and we could track our work along the way. We connected key events during the year to milestone deadlines.

4. Next, we asked ourselves who outside the team had a stake in our success or failure. We wanted to identify these stakeholders and learn how to communicate with them. *(See the Stakeholder Mapping Tool and Communications Tool in the appendix.)* For our purposes, we defined stakeholders as groups or individuals inside or outside our organization who have some influence on our ability to achieve our objectives. People who can help or hinder us would be critical to the success of our work. As we thought about the stakeholders, we realized that they included groups like the following: the leadership group, other units, the state department, community groups, television and print media, and the courts.

We had little or no control over many of these stakeholders, yet we had to learn how to influence them in order to be successful. Whether they initially agreed with us or not was beside the point. The key to influencing them would be to find some areas of shared interest where what we were trying to accomplish in some way enhanced their ability to achieve their objectives. We began by thinking less about what we wanted from each stakeholder and more about their goals. If we could identify their interests, we could in many cases figure out where we could align with them.

5. We selected points along the way where we needed to communicate with key stakeholders. We set specific times, for example, to meet with the leadership team to make sure they authorized the recommendations we wanted to put into action. By providing them with information in advance of a deadline, they were able to think about, react to, and make desired adjustments to what we planned to do. This kept them from being too surprised by how the work evolved and kept our authorization clear.

6. We ended up with a map of meetings that included team meetings as well as contact times with key stakeholders. The meetings map helped us plot over time what we needed to accomplish by when and with whom. *(See Using a Meetings Map for an example.)*

7. In effect, what we had created was a system of activity directly targeted at achieving specific outcomes. Meetings became points along the way where we came together to make decisions and think strategically about issues that we had prepared to address between meetings. As much work, e.g., data

We selected points along the way where we needed to communicate with key stakeholders.

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gathering and conversations with the media, took place outside of meetings as inside because the meetings system gave us a track to run on. We always knew where we were in the process and where we were headed.

The meetings system also made it easier to figure out what the objectives and agenda for each meeting needed to be. We knew that we had specific milestones to reach by specific times. Over time, rather than being the "It's 9:00 a.m., it's time to meet" type, our meetings became both thoughtful and action oriented.

Over time, project management and people management became part of the same process.

We made decisions, followed through on them and invited people from outside the group to participate as needed. We created a real feeling of forward progress by linking one meeting to the next. Of course, we did not hit all our goals at the exact time we planned and things changed along the way, but we were still able to reach the overall result we wanted. Since we included the people along the way who needed to execute the work, we built the kind of ownership we needed as well. Over time, project management and people management became part of the same process.

What We Learned

When our efforts began, I was worried that we might fall into the trap of being an all-planning and no-action team. I had participated in groups in the past that struggled with analysis-paralysis and thought they were deadly. Others agreed with me. We originally decided to use our first three meetings to build the project management framework and then "get to work."

We did not realize at first that our framework, with its milestones, timelines, and meeting map, was moving us in a direction that combined planning and action. Once we had our framework in place, we were able to move back and forth between planning and action. In fact, even at our first meeting one team member came up with an idea that we could implement right away. We decided that we needed to become better at developing the skills of our staff in a consistent way. Before things were somewhat hit or miss on whether a social worker was helped in developing her skills. We decided to create a system of mentoring and coaching that would help the more experienced personnel share their wisdom with the newer staff. While this took awhile to get off the ground, we left that meeting with a group of people having volunteered to start creating a statement of the professional standards of our office and how we would help everyone achieve them.

We learned along the way that there are hundreds of project management tools out there. When we began, we were lost. We needed a framework within which we could select and use tools appropriate to our specific needs. Through trial and error we discovered that the combination of meetings mapping and stakeholder management tools enabled us to build that framework. The meetings map outlined what we needed to accomplish by when. Stakeholder analysis outlined whom we needed to work with at what points along the way.

Once we had the framework in place, we were suddenly able to see how different project management tools could be helpful in different kinds of tasks. Those tools helped us accomplish things like building productive meeting agendas, using our time effectively, charting work flow, and using different ways to gather data to help drive decisionmaking. With the framework to fall back on, it was possible to learn these others tools as we needed them and provide enough organization and thoughtfulness to be selective about where and how they were used.

Like many social workers, we have never given up hope that there will be a magic tool or technique out there that will decrease our workload and increase the quality of our

work at the same time. For the time being we have decided that there is no magic tool that can solve all our problems. It depends on how the tools are used by our team. We did, in the end, devise a solid system for developing our new staff and even old folks like me learned a lot as a result. By treating ourselves as professionals entitled to a system that helps us develop our skills and holding ourselves to a professional standard with all the responsibilities that go with it, our office became a better place to work and served the community more effectively.

For further discussion of Case Study Four see the following:

- ❑ Tool A: Stakeholder Mapping
- ❑ Tool B: Communicating
- ❑ Tool C: Using a Meetings Map
- ❑ Tool D: Building a Meeting Cycle

Case Study Four – Tool A: Stakeholder Mapping

Why

Stakeholder mapping helps in managing change by:

- ❑ Revealing a network of support and opposition to a proposed *initiative*
- ❑ Clarifying strategies for strengthening support and contending with opposition

It encourages participants to look beyond typical exchanges with the most obvious stakeholders and anticipate actions that might derail their efforts.

What

Stakeholder mapping categorizes people and groups according to their attitudes toward and their ability to influence an initiative. It helps participants create strategies for managing these stakeholders.

Where

Stakeholder mapping can be used with supervisor and management teams, task force groups, and special project teams. It can be used easily with small or mid-sized (up to 15) groups. It can be used with larger groups if the task and group can be divided after stakeholders are identified.

When

Stakeholder mapping can be done during the planning stages of an initiative – to clarify communications strategies, for example, among key people and groups – or at the concluding stages when participants are looking ahead to implementation.

How to Create a Stakeholder Map

Create a stakeholder map by following these steps (see Example: Stakeholder Map):

1. ***State the objectives of the task, project, or initiative.***

Participants should be able to agree regarding their objectives. The objectives should be expressed in a few brief statements. In practice, stakeholders will base their reactions on little more than these statements or their equivalents.

2. ***Identify as many stakeholders as possible.***

Stakeholders should be identified as specifically as possible, by name or title, or by groups. List each interest separately even if the parties share the same title. For example, if members of an executive group are stakeholders and divided on an issue, they might be listed as two groups, one for and one against.

3. ***Identify where the stakeholders stand.***

Ask: "How does a proposed task affect the stakeholders?" It helps to briefly characterize their situation at present, contrast it with their situation after any planned change, and then consider their likely reaction. In general, per-

Stakeholder mapping categorizes people and groups according to their attitudes toward and their ability to influence an initiative.

The best strategies are those that induce the most cooperative behavior from the most powerful stakeholder groups.

sonal values (security, power, survival, status, achievement) will dominate organizational values (efficiency, effectiveness) in influencing attitudes.

Scale:
++ = strongly favor
+ = favor
0 = neutral
- = oppose
- - = strongly oppose

Each participant ballots separately prior to discussion to see how much agreement there is among the group.

4. *Assess stakeholders' power.*

Assess stakeholders' power with respect to adoption of a proposal on the one hand and implementation on the other hand.
The following scale may be used:

pp = very powerful
p = powerful
n = not powerful

5. *Determine whether there are coalitions.*

Stakeholders increase their influence by forming coalitions. Scan the list of stakeholders to see if any groups are likely to join forces in support or opposition to a proposal.

6. *Rethink proposal in light of the preceding analysis.*

Are there any alternative policies or practices (or implementation strategies) that could decrease the opposition without alienating support? With a map of stakeholders that provides a picture of everyone's interest, you are better prepared to assess the impact of making changes and to consider alternative courses of action if necessary.

7. *Develop strategies.*

After taking the above steps, the group will have a good picture of key opponents and supporters and will have considered a number of options and their possible effect on stakeholders. This information can now be assembled to construct strategies that enhance the group's objectives. The best strategies are those that induce the most cooperative behavior from the most powerful stakeholder groups. (See *Example: Stakeholder Map-Activity/Stakeholder/Outcome Matrix)*

Attitude Toward the Organization's Objectives or Planned Change		
Stakeholders	Attitude	Stakeholder Objectives and Values that Motivate Their Attitude

Stakeholder's Power			
Stakeholder's Power		**Coalitions**	
Adoption	Implementation	Who Influences Them?	Whom Do They Influence?

Activity \ Stakeholder	Training and Development Dept.	Case Worker Team	Clients
1. Continue to pursue development (read, attend seminars, strengthen presentation skills, learn things that could enhance courses)	Enhances course's message and delivery of message; creates pride in the work/program	Strengthens our delivery skills and increases self-confidence, credibility	Receive a more meaningful message; improve application of program in the field
2. Identify and enact best practices in communication with each other and with clients	Provides future material, i.e., case studies – understanding of needs in the field	Provides consistency	Provide concrete examples
3. Follow up (after teaching course); build in follow-up tools and effectiveness measurement for/of accountability (see #2)	Provides opportunity for revision of programs; helps ensure success of programs	Opportunity of redesign and design of future programs; focus on results	Support the field management team and improve future courses
4. Build management involvement in courses	Creates pride of ownership	Relationship building with management	See the managers as knowledgeable and involved in services development
5. Participate at beginning of corp. Ed. design of courses (see #2)	Receive more input; more "on target" training programs	Pride of ownership; integration of existing programs	More useful training
6. Build and share stock of stories through own experiences and reading	Provides future material, i.e., case studies – understanding of needs in the field	Provides consistency	Provide concrete examples
7. Create systemic follow-up; involve others	Feedback; "continues the chain"	Leaves others in position to continue the work	Seamless service
8. Teach/deliver courses	Consistent, quality delivery of programs	Delivery/learn more when you teach	Receive quality programs
9. Get certified	Consistent, quality delivery of programs	Delivery/learn more when you teach	Receive quality programs

Provide the participants with the support they need to stay in touch with each other.

Case Study Four – Tool B: Communicating

Why

Communication is a key part of any initiative. To maximize its chances of success, you should make sure to stay in touch with many different stakeholders – departments, regions, groups, individual managers, and executives. They must be able to understand its purpose and how they will be affected by the outcome. In the end, their support may determine whether your most important goals are met. Without it, even the best work will fail to achieve a lasting impact.

What

A communications plan identifies stakeholders; effective ways of communicating with them; and the purpose, timing, and content of the communications. Channels of communication include:

- ❑ Meetings
- ❑ Memos
- ❑ E-mail
- ❑ Web sites
- ❑ Voice mail

Each one has pluses and minuses. For example, meetings encourage give and take, but they are time consuming. Memos allow you to state your points carefully, but they compete for attention with lots of other paper communications. E-mails combine the virtues of written and spoken communication, but they often appear in your mailbox along with dozens of other messages and get lost in the shuffle. A Web site can be dazzling and informative, but people may have trouble accessing it. Voice mails can be quickly composed and distributed, but they vanish without a trace. A plan weighs these trade offs and opts for the right mix of channels given the options.

The plan should also develop guidelines for materials and content appropriate for sharing with different audiences. One of the early decisions you will make is about the amount and kind of input needed from stakeholders and how much to publicize the ongoing work of the initiative.

Where

The workgroup manages communication, deciding when and how to publicize an initiative's work. The task of drafting a communications plan might be delegated to a specialist, who may be part of the core group but does not have to be. The specialist may also write memos and e-mails and maintain a Web site once the initiative is underway. Senior executives may need to provide authorization for selected communications.

When

The process of communication often starts before an initiative is formally launched. It continues through all of its phases, until the work is handed off to the executive sponsors.

How to Manage Communications

Before an initiative is launched ...

- ❑ Get clear authorization – written, if possible – from the executive sponsors. If possible, distribute the written charge from the sponsors to participants.
- ❑ Send out word to participants and stakeholders. Be clear about goals, steps in the process, who is involved, and how to find out about the work as it is being done. Use Project on a Page to show at a glance the planned beginning, middle, and end of an initiative. This will help stakeholders decide when and if they want to get more actively involved in the process.

Once the initiative is underway ...

- ❑ Provide the participants with the support they need to stay in touch with each other. For example, they might want to have electronic listservers established. Or they may request that a communications

specialist be assigned to their working groups. Participants can reduce the number of meetings they need if work is being shared along the way through other means. Face-to-face meetings can be used for linking together pieces of the larger effort and for interactive discussion of early drafts or recommendations.

- ❑ Make sure that the executive sponsors receive frequent briefings. Ask them how often they would like to be briefed and in what forms (memos, e-mail, slides, reports, meetings, etc.).
- ❑ Give frequent updates to stakeholders. Use multiple channels (memos, e-mail, Web site). Do spot checks to see if the stakeholders are hearing enough, or too much, and are comfortable with the channels being employed.
- ❑ Call meetings when you:
  - ■ Need two-way communication about difficult or ambiguous issues. In this situation, you should strongly encourage face-to-face discussion among the participants for two reasons. One, they need to understand as much of the context as possible. Written communications often leave too much room for interpretation. Two, they should pick up the intended tone in what they are hearing about the work to date. Ambiguity tends to make people wary. The give and take of discussion helps clarify the way in which words are meant.
  - ■ Want to convey the significance of an issue. When participants are asked to invest their scarce time in a meeting, they come expecting to do important work.
- ❑ Use real-time, interactive technology for quick check-ins about limited issues or questions on which more than e-mail correspondence is needed.

When the initiative is completed ...

- ❑ Thank the participants. You can do this through written communications or a short, celebratory meeting.
- ❑ Document and publicize the results. No lengthy reports are necessary or even desirable, but you should summarize the work in writing. You can post conclusions on a Web site, distribute an e-mail that highlights key findings and recommendations, or send out a package of materials – slides, charts, briefing notes, executive summary – that provide stakeholders with a more detailed record. Depending on the scope of the initiative, you may want to do a mix of these alternatives.

Case Study Four – Tool C: Using a Meetings Map

Why

An initiative includes many different kinds of meetings. Meetings where every participant is present, workgroup meetings, meetings with the executive sponsors, meetings with important stakeholders – taken together, all of these make up an interconnected *system* of meetings, which very quickly becomes complex. With a meetings map, you can see the entire system at a glance and identify those parts that need to be managed carefully.

What

With a meetings map, you can see:

- ❑ Dates when the entire initiative group is meeting and the topics that will be covered
- ❑ Opportunities to check in with the executive sponsors
- ❑ Frequency of the steering meetings
- ❑ Stakeholders who have been included in the process
- ❑ Tasks that have been given to the workgroups

Make sure that the executive sponsors receive frequent briefings.

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By displaying all of this information in one place, you see how all of the parts fit together. Because initiatives are so complex, participants often forget where their work is headed and how it contributes to a common set of goals. A meetings map shows this in a vivid, graphic way. For a demonstration of this point, look at the sample maps at the end of this section.

You can use a meetings map to flag problems in a proposed initiative plan. For example, you might discover:

- ❑ *The same group of people meets too often or not enough.* You might see that a workgroup is scheduled for meetings twice a week. Depending upon the phase of the initiative, it may need to meet this often, or maybe it could reduce the number of scheduled meetings and still accomplish its tasks. On the other hand, a workgroup that has only one meeting scheduled during a long, complex initiative will probably need to get together more frequently.
- ❑ *One person or group is meeting on separate occasions with many other people or groups.* You might see that one person or group is scheduled to have many different meetings with many different people or groups. If so, you should ask yourself: "Could some of those meetings be combined?"
- ❑ *Many groups are addressing the same issue.* You might see that different groups are meeting at different times on the same issue. If so, you might consider combining the meetings or having different groups work on different parts of a larger issue. If they do meet separately, they can eventually come together to discuss how to integrate the work they have been doing.
- ❑ *Some meetings are not clearly linked to other meetings.* You might see that some meetings seem to stand on their own, with little or no obvious linkage to other meetings. If so, you should consider whether the participants' time will be used efficiently. For the most part, meetings should take up issues over time, supported by work in between – they should be part of *meeting cycles*.
- ❑ *Some groups are not meeting with other groups at all.* You might see that one group is not scheduled to talk to another group. If so, there may be "missing" meetings in the initiative.
- ❑ *Some issues are not being discussed.* You might see that some part of a larger problem is not being discussed enough. For example, the larger problem may be helping create stronger linkages and better handoffs between intake, investigation, and assigning case workers to cases. If your current plan has not allocated enough time for understanding how each of these units currently works and where the constraints are, then you should make more time for this topic – and maybe schedule a meeting that focuses on it.

You can use a meetings map to flag problems in a proposed initiative plan.

Where

Initiative leaders and workgroup leaders frequently use meetings maps to keep track of the process and review its progress with other participants. For example, it often helps to begin a meeting by discussing the map, which reminds people of the initiative's goals, timelines, and structure. Meeting support staff usually produce the maps in consultation with the leaders.

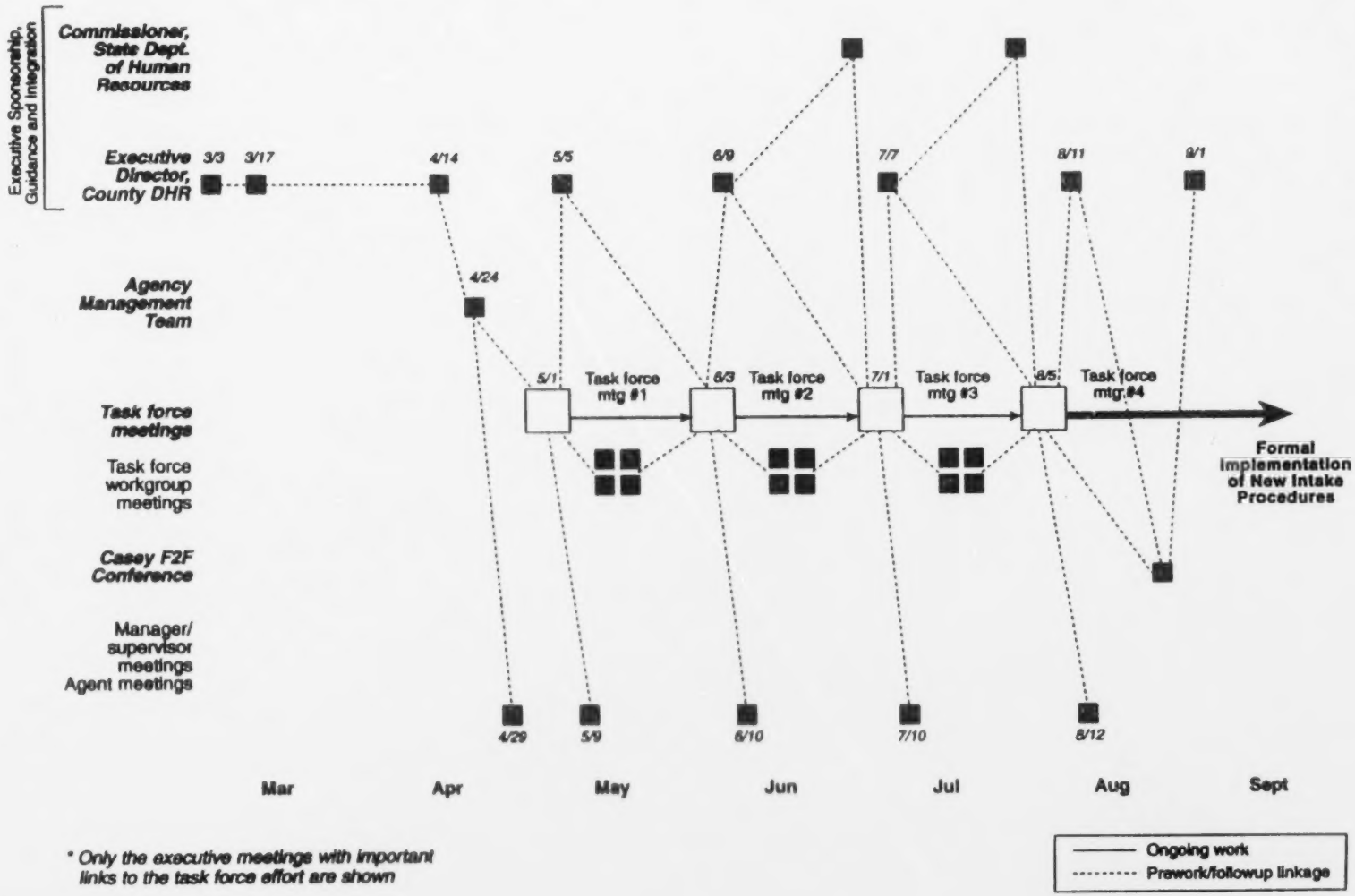
When

A meeting map is used at every stage of a meeting cycle or initiative. In the planning stage, it identifies the places where the work of several different groups needs to be shared and coordinated. As suggested above, it also helps keep an effort on track once it is underway and provides a method to assess results when an initiative is over.

How do you create a meetings map?

1. Start with a sheet of paper. Across the bottom, draw the timeline of the initiative, highlighting the starting and the concluding dates.

Task Force Meeting Map/Improving Intake Time



* *Only the executive meetings with important links to the task force effort are shown*

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2. Down the left hand side of the paper, list the key players – individuals and groups – who will be working together during this time. This should include the executive sponsors, the initiative leaders, the steering group, the initiative group, and the workgroups. Other groups may be included.

3. Note when you think these people and groups need to meet.

4. Connect the meetings with dotted lines. Use the lines to show places where *prework* and *follow-up* are needed and where a group will be handing off deliverables.

5. Look at a draft map and ask yourself questions such as:

- ❑ Are all of the important issues raised by the initiative being addressed?
- ❑ Could some issues be combined into one meeting?
- ❑ Could some groups meet less if they met about a number of issues at the same time?
- ❑ Are some groups addressing an issue separately and not sharing the results of their work?
- ❑ Are some groups who need to be communicating not meeting at all?
- ❑ Is prework being used to adequately prepare participants for a meeting?
- ❑ Is follow-up being used to ensure that work done at a meeting is carried forward?

6. Adapt the map to answer the specific questions you want to ask. The goal is to provide an overview at a glance of the entire meeting system. This goal can be accomplished by using different kinds of maps – be creative in drafting one that suits your purposes.

7. Consult with key members of the initiative leadership to get their feedback about the draft map. Then prepare a final version.

Building cycles of prework, meeting, and follow-up increases the chances that your meetings will be productive.

Case Study Four – Tool D: Building a Meeting Cycle

Why

Building cycles of prework, meeting, and follow-up increases the chances that your meetings will be productive. In a cycle, participants have a chance to get ready ahead of time, focus their discussions when they are together, and afterwards think further about the key issues that have been raised. All of this helps work get done.

The cycle is important because a meeting is rarely if ever an end in itself. Work flows into and out of a well-designed meeting. Prework and follow-up help facilitate that movement.

What

Building a meeting cycle describes how you can design a meeting, identify its prework, and anticipate its follow-up. These three activities help you accomplish the task for which the meeting was called.

A prework assignment is the first part of the cycle. It gets the participants ready to work. It may be an article to read, a set of questions to answer, or a survey to be completed.

Ideally, a meeting builds on the prework. For example, participants might apply a few of the central ideas from an article to their own experience. Or they might gather in small groups to review the results of a survey and then share interpretations with each other.

Follow-up is an opportunity to keep building on the work done in a meeting. Follow-up memos guide that work by emphasizing the most important things that have been accomplished and by indicating next steps. Follow-up tasks are things that call for individual efforts – such as data analysis, writing, or conversations – and may require more time than a meeting allows.

Where

Meeting cycles can be built by the people who will be leading a meeting or by those who are supporting them.

When

You should start planning a cycle at least two weeks before a meeting. You need time to design the meeting before determining the prework assignment. Then you will need time to assemble the needed materials – readings, questions, data – and distribute them to the participants a few days beforehand. This almost always takes longer than expected.

How to build a meeting cycle

Before the meeting...

Take these steps	**Key question for each step**
1. Clarify objective	What would you like participants to do, or how would you like participants to think, differently after the meeting than before?
2. Determine participants	What is the right number and mix of participants?
3. Organize the meeting into stages or "modules"	How does each stage of the meeting contribute to achieving the overall objective of the meeting?
4. Match tools to task	Which tools can we use at each stage of the meeting to facilitate participation and work?
5. Assign prework	What preparation will the participant need to accomplish the objective of the meeting?
6. Anticipate follow-up	If the meeting unfolds as anticipated, what will participants need to carry the work forward?
7. Review design	Do we have the participants, tools, and time to achieve the objectives of the meeting?

During the meeting...

Take these steps (which often overlap)	**Key question for each step**
Facilitate discussion	How can you help participants contribute?
Monitor progress	What changes may be needed to meet the objective?
Check in with participants	How do others experience the meeting?
Take notes	What do we need to remember to keep the work moving forward?

After the meeting...

Take these steps (which often overlap)	**Key question for each step**
Write follow-up memo	What were the objectives, accomplishments, and next steps decided in the meeting?
Monitor follow-up	How can you help participants keep the work on track?
Build the next meeting cycle	What is the objective for the next meeting?

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